Investigation into the death of a man at HMP Dartmoor on 24 May 2012

Report by the Prisons and Probation Ombudsman for England and Wales

August 2013

This is the report of an investigation into the death of a man who died on 24 May 2012 at Derriford Hospital, Plymouth, while in the custody of HMP Dartmoor. His death was recorded as due to a stroke. He was 65 years old. I offer my condolences to his family and friends.

The investigation was conducted by an investigator. NHS Devon commissioned a doctor to undertake a clinical review of the man's healthcare at the prison. Dartmoor cooperated fully with the investigation.

The man saw the prison doctor on 1 May 2012, after experiencing dizzy spells. He saw two nurses afterwards who thought his symptoms could be as a result of anxiety as there were no obvious physical indicators. On 14 May, the doctor referred the man to hospital where it was considered he might have a brain tumour. The man collapsed while at the hospital for tests the next day and was admitted as an inpatient. On 17 May, it was confirmed that he did not have a brain tumour but had suffered a massive stroke. The man's condition deteriorated over the following week and he died in the early hours of 24 May.

While the clinical reviewer considered there were no symptoms to justify referring the man's for a hospital assessment earlier than 14 May, it was of concern that not all the nurses at Dartmoor were appropriately trained to recognise and act on medical emergencies. The clinical reviewer also recommends that Dartmoor should introduce health checks which include an assessment of the risk of vascular disease and should have structured care programmes for prisoners with long term conditions.

The man's family were able to be with him much of the time during his last days, but I consider the prison should have informed them as soon as he was admitted to hospital on 15 May, rather than waiting till the next day. I also believe that Dartmoor should ensure that it is able to deploy a trained family liaison officer as soon as a prisoner is diagnosed with a terminal illness and that consideration should have been given to releasing the man on temporary licence.

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

CONTENTS

SUMMARY

1. On 12 April 2012, the man was transferred from HMP Exeter to HMP Dartmoor. At his reception health screen, he said that he had no current health problems or disability. He was a smoker and had hypertension (high blood pressure) and high cholesterol, for which he took medication.

2. On 1 May, the man reported having dizzy spells. The doctor noted that the man suffered from high blood pressure which was well controlled. However, the doctor considered that the man might be suffering from a nerve irritation in his right elbow and recommended he had blood tests.

3. The man saw a nurse on 9 May, complaining of dizziness and blurred vision. The man said his arms felt 'detached and not controlled.' The nurse diagnosed possible anxiety. The next day, another nurse was called to the man's cell as he was concerned that he might have had a stroke. She examined him but found no obvious signs of a stroke. He appeared to be anxious and she discussed anxiety management with him and booked a doctor's appointment. Both the nurses were registered mental health nurses.

4. The man returned to healthcare on 13 May, and said he had acute pain in his right arm and constant numbness in his left leg. He also said that his ability to judge objects on his right side was impaired and he could no longer write. He said it took extreme concentration to pick up and hold a drink in his right hand. He thought he had experienced a stroke, so the first nurse asked him to record his symptoms and brought forward his doctor's appointment.

5. That night, the Night Duty Manager was called to A wing as the man said he had numbness in his arm. She noted he was able to move his arm, had no other problems and had a doctor's appointment later that morning. She saw that he was able to dress himself, make his bed and roll his own cigarettes.

6. Later that morning, the man was examined by a doctor, who noted that his gait was unsteady, his right forearm and hand had lost muscle tone, and he had lost power in his left knee. The doctor arranged for an assessment at Derriford Hospital where the man was examined by a consultant who, suspecting a brain tumour, arranged tests for the next day.

7. The man returned to the hospital the next day and collapsed shortly after arriving. He recovered but collapsed again. He was admitted for further investigations and, on 17 May, a doctor confirmed that the man had suffered a massive stroke. His condition deteriorated and he died on 24 May.

8. We make seven recommendations. Three of these concern training of healthcare staff, the provision of long term plans for structured care and full assessments on arrival. Another three concern liaison with families when prisoners are seriously ill. The final recommendation concerns the consideration of release for terminally ill prisoners.

THE INVESTIGATION PROCESS

9. This office was notified of the man's death on 24 May 2012. Notices announcing the investigation were supplied and displayed by the prison to staff and prisoners, who were invited to contribute any relevant information. A prisoner had helped the man compile a list of his symptoms so he could inform the prison doctor of them. The prisoner gave the investigator this list for our information.

10. The investigator visited Dartmoor on 29 May. He visited Arch Tor wing (A wing) where the man lived and spoke to several prisoners who had known him. He visited the healthcare centre and spoke to the manager. The investigator also collected the man's prison records, including his main prison record, his medical records, statements made by staff, escort record forms and bedwatch logs.

11. A clinical review of the man's healthcare was undertaken by the Medical Director for NHS Devon. In addition the Risk Management Team, Devon Partnership NHS Trust undertook a Root Cause Analysis (RCA) investigation to establish whether the man's condition was adequately assessed and treated. A member of staff from NHS Devon was appointed to carry out the RCA and she assisted the reviewer with the clinical review. In her RCA, she concluded that the man's family history of heart disease, high blood pressure and cholesterol, and consumption of tobacco (20 cigarettes per day) and alcohol (72 units per week before prison) were contributory factors to his stroke.

12. HM Coroner was informed of the investigation. The Coroner advised that there would be no post mortem examination as the man had died in hospital, his cause of death was known by the doctor in charge of his care, and the man's family did not want a post mortem.

13. One of our family liaison officers contacted the man's wife and family to give them an opportunity to raise any concerns or issues they wished to be considered as part of this investigation. The family liaison officer and the investigator met the man's family and they raised a number of concerns. Not all were directly related to the circumstances of his death and we have dealt with these in correspondence.

- The man's wife was very concerned about the care her husband received while at Dartmoor. She explained he was receiving medication for hypertension and high cholesterol for a number of years and that this should be recorded on his medical records (which it was). His family said they had contacted the prison on a number of occasions to raise their concerns about his health but were unable to speak with anyone from health care. They were re-directed to the Chaplain, which they found unhelpful.

- From 29 April until his hospital admission, the man repeatedly told his family about the symptoms he was displaying, such as dizziness, numbness to his hand, arm and leg and how they were getting worse. He believed he had had a stroke but was unable to see a doctor until 14 May, when he was admitted directly to hospital.

- The man's family were not told of his condition or his admission to hospital until the following day. They wanted to know why they were not informed immediately.

- The man's family wanted to know why he was being escorted by two prison officers, when it was known he was dying, as they found this deeply distressing. The man's wife explained most of the officers were sensitive and understanding and sat outside the room when his family were with him.

14. This version of the report has been amended following feedback on the draft report.

HMP DARTMOOR

15. HMP Dartmoor is a category C secure training prison for adult men. There are six wings.

16. Healthcare is commissioned by Devon Primary Care Trust. Health services are provided from 8.00am until 8.00pm Monday to Thursday, until 5.30pm Fridays and up to 5.00pm Saturday and Sunday, with a doctor and specialist clinics available. Overnight and weekend cover is provided by an out-of-hours service, Devon Docs, who are commissioned to deliver in-hours and out-of-hours medical services. There is no inpatient facility.

Her Majesty's Inspectorate of Prisons (HMIP)

17. HMIP last inspected Dartmoor in December 2011. Inspectors noted about health services that:

> "Health care facilities were good but service provision was inconsistent and affected by staff shortages. Some clinics had not been run for some months. There were not enough GP clinics, which had been exacerbated by staff sick leave."

Independent Monitoring Board (IMB)

18. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The most recently published IMB annual report for Dartmoor covers the year to 29 February 2011. At that time the IMB were concerned about staff shortages in health care but noted that clinics in the prison were run regularly. The IMB also noted that money saved by closure of health care beds at HMP Exeter, part of the healthcare cluster which includes Dartmoor, had not led to any additional resources to support the health needs of prisoners at Dartmoor.

KEY EVENTS

19. On 27 March 2012, the man was sentenced to 16 months imprisonment and was sent to HMP Exeter. During his first night interview, he stated it was his first time in custody and he had no serious worries. He said he did not feel at risk of self-harm. He had been convicted of a sexual offence and agreed to be held under Prison Rule 45, which allows prisoners to be kept apart from other prisoners for their own safety.

20. During his reception healthscreen that evening, it was noted that the man was prescribed lisinopril for hypertension and rosuvastatin for high cholesterol. The man said he had a limp following a broken left heel but had no recent physical injuries. He had no chest pain, did not suffer from asthma or epilepsy and had no concerns about his physical health. He was found to be fit for normal location, work and to occupy any cell. Exeter obtained a summary of his healthcare records from his community GP. .

21. The following day, the man completed his induction. He had a second healthscreen which noted that he had a scar on his left foot which periodically opened up. This had been treated by his doctor six weeks earlier when he was given antibiotics. The man was given a hepatitis B vaccination. He told the nurse he had a history of anxiety and depression and a family history of hypertension and coronary heart disease. He said he was a smoker. His blood pressure was found to be normal.

22. On 29 March, the man was categorised as a Category C prisoner and, on 12 April, he was moved to HMP Dartmoor. He was seen on arrival by a Registered Mental Health Nurse (RMN). She noted that the man had no current medical issues or disabilities. He stated he was a smoker and suffered from hypertension. She noted his prescribed medication.

23. On 1 May, the man saw a doctor, and said he was having giddy spells. The doctor noted that the man suffered from high blood pressure which was sufficiently controlled, might be suffering from a nerve irritation in his right elbow and needed blood tests to determine his risk of coronary heart disease, diabetes, and his cholesterol levels.

24. On 9 May, the man had a dizzy spell and said that his eyesight was blurred. He was taken to the healthcare centre and was seen by a second RMN. The man said that his arms felt ‘detached and not controlled’. The second RMN noted the man’s observations as temperature 35.8, blood sugar 6.0 (normal value range), pulse 80, oxygen saturation 99% (normal) and blood pressure 120/78 (normal).

25. After speaking with the man, the second RMN diagnosed possible anxiety issues. The man agreed to look at library books about anxiety management. He agreed to contact the Buddhist chaplain for guidance on meditation and to consider attending Tai Chi. The man said he would apply for an optician’s appointment. The second RMN told him that further support from healthcare was available should the symptoms continue.

26. At lunchtime on 10 May, the RMN was called to A wing as the man was concerned that he might have had a stroke. She examined him and noted his blood pressure as 140/90 (slightly high) and pulse as 80. His pupils were equal and reacting to light, he was able to communicate, had no weakness on either side of his body, and no loss of tone or power in his limbs. She noted that there were no obvious signs of a stroke. She recorded that the man appeared to be anxious as he maintained he was wrongly convicted and because a visit had been cancelled as prison staff were taking industrial action. [In response to the draft report, the man's family said that he had called them that morning and had told them that his right leg was completely numb.]

27. The RMN considered that the man might have an anxiety disorder. She discussed anxiety management with him, encouraged him to verbalise his worries and concerns in a therapeutic manner and confirmed that he appeared physically well. The man said he felt relieved that he was not having a stroke but would like to see the doctor to discuss his anxiety. The RMN told him that she would book an appointment for him. She told him to contact healthcare if he had any problems, or ring his cell bell overnight.

28. The man returned to healthcare on 13 May, and saw the second RMN and reported that he had acute pain in his right arm and constant numbness in his left leg. The second RMN noted his observations as blood pressure 132/80 (again slightly high), oxygen saturation 97%, and pulse 78. The man told the nurse that his ability to judge objects on his right side was impaired and that he could no longer write. He also said that it took extreme concentration to pick up and hold a drink in his right hand. Again he said he thought he had had a stroke. The second RMN asked him to keep a diary, using a "buddy" (where prisoners help each other) to record all observed symptoms and said she would try and bring forward the doctor's appointment.

29. A senior officer was the Night Duty Manager on 13 May. She was called to A wing at 2.40am on 14 May as the man said that his arm was numb. She spoke to him in his cell and recorded on the daily briefing sheet that he was able to move his arm and had no other problems. She also noted his ongoing medical problems and that he had a doctor's appointment later that morning. She recorded that he was able to dress himself, make his bed and roll cigarettes. [In response to the draft report, the man's family said that he had called them that morning and was upset because his hand was completely numb. That afternoon, he told them that another prisoner had helped him dial the number.]

30. At 11.21am on 14 May, the man was examined by another doctor. The doctor found no problems with the man's speech or other senses. The man told him that on 9 May, he had had a dead leg, on 13 May, he had had a loss of fine movement in his hand and that day he had numbness in his right hand. The doctor noted that the man had an unsteady gait, loss of tone in his right forearm and hand and a loss of power of his left knee extension. He arranged for an immediate assessment in Derriford Hospital as he thought there might

be a neurological cause (associated with the nervous system) for the man's symptoms.

31. At 2.47pm the same day, the man arrived at Derriford Hospital, escorted by two prison officers. He was examined by a consultant who decided to conduct tests, including a CT scan (computerised tomography, which uses X-rays to make detailed pictures of structures inside the body), the following day. The working diagnosis established by the consultant was a possible brain tumour. He returned to Dartmoor at 5.30pm.

32. For this visit to hospital, the man was escorted by two officers in a taxi and restrained using handcuffs, which were authorised by the duty governor. The reasons for the use of restraints were given as the risk of him re-offending, his security category and the fact that he had told his family about the medical appointment.

33. On 15 May, the man returned to the hospital. Restraints were used again, but duty governor had authorised that they could be removed during medical examinations and treatment. At 10.45am, while having a cannula (a tube that can be inserted into the body) filled, the man collapsed and was attended to by a doctor and three nurses. He recovered and was taken in a wheelchair to the X-ray department.

34. At 11.41am, the man collapsed again. The escorting officers removed the handcuffs and helped a nurse move him to the floor. He was attended by a number of hospital staff and recovered. He was admitted as an in-patient, had the CT scan and was moved to an observation bed. At 1.34pm, a surgeon informed one of the escort officers that the scan had shown that there was a tumour in the man's brain. The Head of Operations authorised restraints to be removed that evening and they were not reapplied.

35. The next day, 16 May, at 1.55pm the duty governor called the escorting officers to inform them that he had approved a compassionate visit from the man's wife, son and his fiancée. (The duty governor had spoken to the man's wife earlier that afternoon to tell her that he was in hospital.) At 2.10pm, the man went for another scan. At 4.20pm, he was moved to another ward and an hour later his family visited him.

36. On 17 May, the escort officers noted that the man remained unable to control the right side of his body and had double vision. At 2.35pm, he went for another CT scan. At 3.05pm a neurologist examined him and confirmed that he had suffered a major stroke and did not have a tumour. He said the man would be in hospital for a few days.

37. The following day at 3.20pm, the consultant told the officers that the man did not have a tumour but had suffered a very large stroke with a minimum recovery time of four weeks. At 4.30pm, he received a visit from his wife and son's fiancée. They were updated by nursing staff.

38. The man slept for most of the day on 19 May. At 6.05am on 20 May, a nurse examined him. As he did not respond, the nurse gave him oxygen. A doctor then decided the man would need another scan as he was not reacting to pain. At 7.15am, one of the escorting officers contacted the duty governor at Dartmoor, to ask him to contact the man's family as his condition had deteriorated rapidly and the hospital needed to discuss his condition with them.

39. Another further CT scan was completed at 9.40am. His family arrived at 11.15am. At 1.30pm, the escort was reduced to one officer who noted that the consultant had said that the man was expected to die within 48 hours. At 5.40pm his brother and sister arrived to see him.

40. Following the consultant's diagnosis that the man was not expected to live long, his family asked whether he might be released. As a result, staff at Dartmoor began to collate the reports necessary to submit an application for compassionate release. Unfortunately, this application was not completed before the man died.

41. Two members of the prison chaplaincy team visited the man at the hospital on 21 May. They noted that his wife was pleased to see them and she spoke very highly of the support given by the escorting officers. She asked them to pray for her husband and the family, which they did. A further scan was performed at 2.30pm on 21 May. His brother and sister visited that evening, while the man's wife, son and his fiancée remained at his bedside. The duty governor also visited his family during this time.

42. The man's condition continued to deteriorate and, at 10.00pm on 23 May, his wife told the escort officer that his oxygen had been removed. At 5.20 am on 24 May, his death was confirmed by a doctor.

43. A prison family liaison officer was appointed and liaised with the man's relatives. The prison offered a financial contribution towards funeral expenses and a memorial service was held at the prison.

ISSUES

Clinical Care

44. In his clinical review, the reviewer states that the man had a high risk of vascular (circulatory) disease. However, there is no evidence that there is a structured system in place in Dartmoor to assess prisoners for risk of vascular disease when they arrive. Narrowed arteries from vascular disease can cause heart attacks and strokes.

45. Vascular assessments are a useful first step in ensuring that the long-term health needs of prisoners are appropriately met while they are in prison. As cardiovascular disease is the cause of more than a third of all deaths in the United Kingdom, appropriate measure should be in place to ensure that all prisoners are assessed and given advice on how to avoid this type of disease. We make the following recommendation:

The Head of Healthcare should ensure that all prisoners receive a full health assessment on arrival, taking into account their community GP records, and that they are given appropriate disease prevention advice.

46. It is a further concern that there is no system at Dartmoor for the structured care of prisoners with long-term health conditions such as diabetes, respiratory and vascular disease. Such care was previously provided and the reasons why the services had stopped are not entirely clear, although HMIP reported that this was due to staff shortages. The clinical reviewer makes the following recommendation, which we endorse:

The Head of Healthcare should ensure that prisoners with long term conditions have a structured care programme to manage their condition.

47. The clinical reviewer believes that the man's neurological symptoms, while not typical of a stroke, were sufficiently severe to require an urgent review from a GP. The second RMN did bring forward a GP appointment, but despite this there was still a delay in the man being assessed by a doctor- four to five days after he first reported symptoms.

48. The second RMN, a mental health nurse with no general nurse training, assessed the man on 9 and 13 May. At interview it was apparent that he would not be able to recognize an acute stroke, and was unaware of simple diagnostic tests to detect stroke. (A Serious Untoward Incident investigation was held after the man's death and the second RMN was not given any emergency response duties until that investigation was completed.) However, even if he had performed these tests, the clinical reviewer believes that it is highly unlikely that they would have indicated an acute stroke.

49. The second RMN was clear that both he and the man, who had a background in mental health social work, thought that the symptoms were psychological rather than physical. [The man's family commented that he never suggested

that he thought his symptoms were psychological not physical.] At a subsequent consultation, the RMN also considered that the problem was psychological. The clinical reviewer comments that "It would have been difficult to make a diagnosis of stroke on the symptoms recorded in his healthcare notes." When the doctor saw him, he referred him immediately to hospital. Although the man's family said that he was increasingly concerned about his physical health, his health records do not evidence any deterioration in his physical condition until he was seen on 14 May. The clinical reviewer notes that it is impossible to say whether an earlier hospital referral would have made a difference to the outcome. However, he states that there was no medical justification for a referral any earlier than 14 May. It therefore appears that the previous diagnoses of the nurses did not affect the outcome in the man's case. Nevertheless, it is important that all healthcare staff have sufficient training to recognise and deal with the symptoms that indicated a need for urgent referral to a doctor or hospital. We make the following recommendation:

The Head of Healthcare should ensure that all healthcare staff have the appropriate training to recognise, treat or deal with medical emergencies.

Notification of serious illness

50. The man's family asked why they were not informed immediately that he had been admitted to hospital on 15 May. The man was taken to Derriford Hospital that day for a CT scan and was not initially admitted as an in-patient. But after he collapsed twice at the hospital he was admitted as an inpatient, early on the afternoon on 15 May. At the time it was thought he had a brain tumour.

51. Prison Rule 22 (1) says that 'If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of 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'. However, the man's family were not told of his admission to hospital until the next day, 16 May, around midday when the duty governor authorised unrestricted visits. We consider that because of the seriousness of the man's condition, in line with Prison Rule 22, his family should have been informed on 15 May. We make the following recommendation:

The Governor should ensure that next of kin are informed immediately when a prisoner is admitted to hospital with a suspected serious medical condition.

Passing on family concerns about a prisoner

52. The man's family said they had contacted the prison on a number of occasions to raise their concerns about his health but were unable to speak with anyone from health care. They were re-directed to the chaplaincy team,

who they found unhelpful. We have been unable to find any record of these calls and, although healthcare were aware of the man's history of hypertension and high cholesterol, there is nothing in healthcare records to suggest that his family's concerns about his health were passed on from the chaplaincy team or anyone else. A family's concerns about the state of a prisoner's health are important and ought to be handled sensitively and recorded so that any necessary action is taken. We make the following recommendation:

The Governor should ensure that telephone calls from families expressing concern about the well-being of a prisoner are logged and dealt with appropriately.

Escort presence

53. The man was in hospital for nine days before he died. On 15 May, he was admitted as an in-patient and restraints were permanently removed that evening, once the seriousness of his condition became known. At first, he was escorted by two prison officers. This was reduced to one when it became clear that he would not recover. The man was terminally ill and an application for compassionate release was being prepared but it does not appear that any thought was given to allowing him to be released on temporary licence until this was decided. This would have allowed him to remain at the hospital without the presence of prison officers, which some of his family found distressing. The fact that restraints were removed, there was only one officer present and that the prison was supporting an application for compassionate release does not suggest that there were any serious concerns about security risks that would have precluded release on temporary licence. We make the following recommendation:

The Governor should ensure that consideration is given to release on temporary licence when a prisoner is seriously or terminally ill in hospital.

Family liaison

54. Prison Service Instruction 64/2011 gives clear guidance on the support that should be offered to the families of terminally ill prisoners. The guidance states that "Prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin or a nominated person of prisoners who are either terminally or seriously ill". While the man's wife was complimentary about the officers, describing them as sensitive and understanding, not all his family felt well supported or informed. Dartmoor should have ensured that a suitable member of staff was available to fulfil this role. We are aware that at the time Dartmoor did not have any trained family liaison officers, although we have been told some staff are now being trained. We make the following recommendation:

The Governor should ensure that when a prisoner is diagnosed with a terminal illness a family liaison officer is appointed to act as a point of contact and support.

CONCLUSION

55. The clinical reviewer found that the man was at high risk of vascular disease. However, there were no structured assessments for this risk and no care programme at Dartmoor for prisoners with long term conditions.

56. The man was seen by two nurses in the weeks leading to his admission to hospital who were not well qualified to assess his symptoms and there is a need to ensure appropriately trained and qualified staff. However, his symptoms were not typical of a stroke and, when he went to hospital on 14 May, the doctor gave an initial diagnosis of a brain tumour rather than a stroke.

57. The man's family were not notified immediately when he was admitted to hospital seriously ill, and there was no trained family liaison officer to support them. An application for compassionate release was begun but there was no consideration of release on temporary licence.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all prisoners receive a full health assessment on arrival, that their GP records are traced and checked, and that they are given appropriate disease prevention advice.

   NOMS accepted the recommendation and commented:

   All prisoners received at Dartmoor are sentenced prisoners. They all have a full Health Screen on arrival at this Prison.

   All will have had an initial health assessment at their Local Prison prior to transfer to Dartmoor. This is when GP records are traced and checked. Assuming that the prisoner is registered with a GP prior to imprisonment, all information received by the Prison Healthcare from GPs is recorded in their electronic medical file. This file follows the prisoner regardless of which prison they are held in.

   Part of the Health Screen at Dartmoor involves signposting/referring prisoners to the necessary specialist in the Healthcare department

2. The Head of Healthcare should ensure that prisoners with long term conditions have a structured care programme to manage their condition.

   NOMS accepted the recommendation and commented:

   All prisoners transferred to Dartmoor have a health assessment. They are referred to the necessary specialist nurses or Doctors at that point. Ongoing care records are held on their electronic medical records (SystmOne) for individuals.

   It is agreed that this pathway is not always clear, and further development of online templates is being undertaken. A SystmOne lead for the Devon Prisons is now in post and will be developing these templates in the near future.

3. The Head of Healthcare should ensure that all healthcare staff have the appropriate training to recognise, treat or deal with medical emergencies.

   NOMS accepted the recommendation and commented:

   Training needs are identified through the annual appraisal system. Due to the ever changing needs of the prison population, there will always be some nursing staff who have more experience in some areas than others. All staff have annual Basic Life Support training, and this is recorded in their personnel records. It is felt that this is sufficient when dealing with medical emergencies.

The Healthcare Training Lead and the Healthcare manager monitor core training levels to ensure compliance. This forms part of the Trust recording and reporting frameworks.
It should be noted that there are also First Aid trained Prison staff available.

On renewal of the Healthcare contract in 2013, core training will be reviewed to ensure adequate training can continue to be provided to staff in the future.

4. The Governor should ensure that next of kin are informed immediately when a prisoner is admitted to hospital with a suspected serious medical condition.

   NOMS accepted the recommendation and commented:

   Policy dictates that families are notified immediately of a life threatening situation.

   On this occasion the establishment were not immediately aware of the seriousness of the situation. NTS will be issued to remind staff to inform management as soon as they are aware of a life threatening situation.

5. The Governor should ensure that telephone calls from families expressing concern about the well-being of a prisoner are logged and dealt with appropriately.

   NOMS accepted the recommendation and commented:

   Concerns from member of the public are now logged and referred to appropriate departments / members of staff.

6. The Governor should ensure that consideration is given to release on temporary licence when a prisoner is seriously or terminally ill in hospital.

   NOMS accepted the recommendation and commented:

   The Governor will ensure that consideration is given to release on temporary licence when a prisoner is seriously or terminally ill in hospital.

7. The Governor should ensure that when a prisoner is diagnosed with a terminal illness a family liaison officer is appointed to act as a point of contact and support.

   NOMS accepted the recommendation and commented:

   Staff trained as Family Liaison Officers will be assigned to liaise as the Single Point of Contact to families whenever the Governor is informed that a prisoner is terminally ill.