PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the circumstances of the death of a man at HMP & YOI Hull in September 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 was found unconscious in his cell in HMP Hull, in September 2012, less than 24 hours after his arrival. He was 43 years old. A post-mortem examination and toxicology tests have been unable to determine a cause of death. I offer my condolences to the man's family and friends.

One of my investigators carried out the investigation and a clinical reviewer conducted a review of the man's clinical care at HMP Hull.

The man had been in Hull previously and some of the prison staff who dealt with him when he arrived already knew him. He said that he had drunk a large amount of alcohol earlier in the day and that he was prone to alcohol-related seizures. He was allocated to the first night and detoxification unit (G wing) but, because of his earlier alcohol intake, clinical treatment for alcohol withdrawal was not begun. Prison staff said they checked him during the night and an officer said he saw him moving in his cell at 6.45am. An hour and a quarter later, he was found unconscious in his cell.

The man spent less than a day at Hull and the clinical reviewer considers that he received appropriate care in that time. We are satisfied that he was appropriately allocated to the detoxification unit, even though there was no clear written guidance to help staff decide when prisoners withdrawing from alcohol should be admitted to the healthcare centre for observation. At the time of the man's death, there was also no system for nurses to record their observations of prisoners during the night, so we cannot confirm the frequency of their checks. When he was found unresponsive in his cell, the emergency response was prompt, although an ambulance was not called until a nurse arrived and a lack of defibrillators meant that it took 15 minutes to get one to the scene. Sadly, there is no evidence that anything further could have been done to revive the man when he was found.

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 **May 2013**

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SUMMARY

1. The man was 43 years old. He arrived at HMP Hull from court on an evening in September. He had been in custody at Hull a number of times previously. On each occasion, he had undergone an alcohol detoxification.

2. When he arrived the man said that he had consumed a large quantity of alcohol earlier that day. However, he did not appear severely intoxicated and was described as alert, able to communicate clearly and steady on his feet. He said that he was taking medication to help prevent seizures and staff planned to check his prescriptions with his community GP the next day.

3. A nurse and doctor from the prison's substance misuse team assessed the man and decided that he should go to the detoxification wing. Due to the amount of alcohol that he had consumed, it was not intended to prescribe any medication for alcohol withdrawal until the next day. His score on an alcohol pathway form indicated that staff should have considered admitting him to the healthcare unit for monitoring, but manager of the substance misuse team said that this part of the procedure had yet to be implemented.

4. The man was given a single cell and was expected to be checked throughout the night. The duty nurse said that he checked him at least three times but there was no system to record these checks. It is not clear whether officers did hourly checks in addition. He was reported to have been seen watching television in his cell during a check of prisoners at approximately 6.45am the following morning.

5. At around 8.00am, an officer unlocking cells looked through the observation panel of the man's cell and saw him lying on the cell floor, apparently unconscious. He went into the cell but was unable to get a response and called colleagues for assistance. Nurses and officers attempted cardiopulmonary resuscitation (CPR). One of the nurses called an emergency ambulance. Paramedics arrived at around 8.25am and continued treatment but they pronounced the man dead at 8.45am.

6. A post-mortem examination and toxicology tests have been unable to provide a definitive cause of the man's death.

7. The investigation found that there was a need for better guidance on conducting observations on newly arrived prisoners withdrawing from alcohol and for determining when such prisoners should be monitored in the healthcare unit. There is also a need to ensure that a defibrillator is taken quickly to the scene of an emergency. Contrary to national guidance, an emergency ambulance was not called until a nurse arrived. This is a matter we have previously raised at Hull, but the Governor had now changed procedures to ensure that any member of staff can now request an ambulance.

THE INVESTIGATION PROCESS

8. Notices were issued to staff and prisoners informing them of the investigation and inviting them to contact the investigator if they had relevant information. No one came forward.

9. The investigator first visited HMP Hull on 27 September 2012, where he met one of the prison's operational managers, a representative from the POA (prison officers' union) and a member of the Independent Monitoring Board. He visited the man's cell and collected his prison and health records.

10. The investigator subsequently returned to the prison on 29, 30 and 31 October and interviewed nine members of staff.

11. The investigator contacted the Coroner's officer and a copy of this report has been sent to the Coroner to assist his enquiries.

12. A clinical reviewer carried out a review of the man's clinical care and treatment on behalf of Hull Primary Care Trust.

13. One of the Ombudsman's family liaison officers contacted the man's sister to inform her of the investigation and to offer the opportunity to raise any issues to be considered during the investigation. She questioned why her brother had been left in a cell alone, and what action the prison had taken in respect of his alcohol problems. The man's sister said that her brother had suffered from seizures and asked whether he had been alive when prison staff found him. Following the issue of the draft report, the man's sister provided a written response in which she expressed her concerns in relation to the findings of our investigation.

HMP HULL

14. HMP Hull is a local prison close to the city centre, holding just over 1,000 remand, sentenced and convicted adult males and young offenders.

Her Majesty's Inspectorate of Prisons

15. Her Majesty's Inspectorate of Prisons' (HMIP) last inspected Hull in an unannounced short follow-up inspection in February 2012. The previous announced inspection at Hull in November 2008, recommended that clinical services should be extended to offer adequate alcohol detoxification. The follow-up inspection found that this recommendation had been achieved and commented:

> "Prisoners arriving with alcohol withdrawal needs were seen by a substance use officer in reception, then health screened by a nurse and transferred to G wing. They were seen by a substance use doctor in the evening and prescribed supportive medication. Men waited a maximum of six hours between arriving and being seen by the doctor for medication. Those with acute alcohol withdrawal needs had 24-hour access to a substance use nurse"

Previous deaths at Hull

16. There have been five deaths at Hull since 2011. In the investigations into two of these deaths, there were concerns about the policy and process for calling ambulances, which were still in force at the time of the man's death. This was an issue in this case, but we have not repeated the recommendation as the Governor has now revised the guidance appropriately.

KEY EVENTS

17. The man was 43 years old when he was remanded into custody at HMP Hull in September 2012. This was not his first time in custody and he had served previous sentences at Hull.

18. The investigator spoke to the reception senior officer (SO) who recalled that the man had told him that he had been drinking that day. Although the senior officer could smell alcohol on him, he said that the man appeared coherent and steady on his feet.

19. The man was one of the last prisoners to be processed that evening. After the initial documentation had been completed, he went to G wing (the dedicated substance use wing and first night centre) to be assessed by a nurse, who recorded:

> '… Initial Health Screen completed on reception. Alcohol intake week before custody – 300 units/week. Appears to be quite fit and healthy. Not fit normal location, work or any cell occupancy at this time. Appears to be mentally stable. No thoughts of self-harm or suicide. Interacted well, good eye contact. States has alcohol seizures so sees GP. Current medication, Thiamine, vit b, clonazepam, and Epilim. ?? Not epileptic …'

20. The nurse did not notice anything unusual about the man and he did not appear to be under the influence of alcohol. The nurse recorded that he said he had been taking medication for alcohol withdrawal, including thiamine, vitamin b and clonazepam as well as Epilim, which is used in the treatment of epileptic seizures. He did not have any of these medications with him, so it was planned that a fax would be sent the next day to his community GP to check his prescriptions.

21. The investigator asked the nurse whether the man had discussed his seizures. He told her that he only had seizures because of his alcohol use and had seen his community GP about this. He did not say when he had last had a seizure.

22. The Compass Offender Recovery Service provides drug and alcohol treatment at Hull. The prison nurse did not speak to the Compass nurse about the man's physical health. When a Compass nurse assesses a prisoner, they do not have access to the medical notes made during the initial health screen and therefore might not be aware of any physical health problems the prisoner might have disclosed. However, staff said that if there were any particular concerns about someone during the initial screening process, they would consult one another. The Compass GP was also available if required.

23. A member of the Compass team, a senior nurse, assessed the man. The nurse said that Compass provides care mainly for alcohol, heroin and benzodiazepines addiction. The team has two functions. Nurses deal with clinical issues, prescribing and dispensing of medication, vaccines, testing and client reviews. The other aspect is psychosocial support and pre-release

planning. The nurse from the Compass team explained that the Compass service combined the role of drug workers in the Counselling, Assessment, Referral and Throughcare service (CARATs) team and the Integrated Drug Treatment Service (IDTS) clinical team, which are usually separated in other prisons.

24. The nurse from Compass knew the man from previous stays at Hull. He detected a strong smell of alcohol, but the man was open, alert and conversant during the assessment. He recorded, at 8.28pm, that:

> '… On presentation [the man] appeared to be slightly under the influence of alcohol, with a strong smell of alcohol. However, he was open, alert and conversant during assessment. His mobility was OK, with a slightly uneven gait and he was able to walk around the induction area without difficulty. [The man] discussed his current levels of alcohol use and stated that he had consumed six litres of 7.5% alcohol cider - which is about 45 units – prior to court that day. In discussion with the doctor and the man, the decision was taken to commence an alcohol detox the following day …'

25. Due to the amount of alcohol the man had consumed before he arrived, the nurse from Compass decided, in discussion with the substance misuse doctor, to start a low dose alcohol detoxification treatment the next day. The nurse completed an alcohol assessment, which is designed to assess the extent of a person's alcohol dependency. A score of 20 or above would place the individual under the care of the Compass team, otherwise treatment would be the responsibility of the general nursing team. The man's score was well above 20. The nurse said that a decision would be made in discussion with the reception nurse, induction staff, Compass nurse and doctor about whether a prisoner should be allocated to G wing for detoxification, or in more severe cases, to the healthcare centre. The man was not considered to be severely intoxicated and the substance misuse doctor and nurse agreed he did not need to go to the healthcare centre.

26. The nurse from Compass said that he understood that all prisoners were checked hourly during their first night in custody but monitoring also depended on individual needs. For someone like this man, who smelt of alcohol on reception, the frequency of observations might be increased. There was no evidence that the level of required observations for the man was recorded, or whether anyone had considered whether there was a need to increase them.

27. The duty Compass GP that evening discussed with the senior nurse from Compass and the man appropriate treatment and timing. They agreed that he did not need to stay in the healthcare wing. The nurse wrote:

> '… [the man] passed through the induction process as usual and [substance misuse doctor] and myself had no concerns regarding placing him on normal location on G wing in a hatch cell and no other parties involved voiced any issues or concerns regarding [the man] …

'… [man] reports that he has seizures, reference alcohol withdrawal, and that his most recent seizure was yesterday …'

The substance misuse doctor also recorded that the man suffered from epileptic seizures. He made no additional plan of care for the seizures and thought that the man presented similarly to previous occasions in custody.

28. The substance misuse doctor told the clinical reviewer that he had assessed the man twice previously at Hull, when he had disclosed that he drank around 6 litres of cider daily. On both occasions, he had been placed on a detoxification regime. He said that the man had not previously been prescribed any medication for seizures and the reasons for the Epilim prescription were not clear. The general medical team were intending to contact his community GP the next day to clarify the reasons for the prescription.

29. The substance misuse doctor told the clinical reviewer that, although the man had consumed a large amount of alcohol earlier that day, when he arrived at Hull he was communicating clearly, steady on his feet and alert. Neither he nor the Compass staff had any reason to believe that he needed to be admitted to the healthcare centre, and believed that his placement on G wing was appropriate. He also explained that communication between the general nurses and those working for Compass was generally good, and they would discuss any concerns. The substance misuse doctor said that as a GP he had access to both the Compass and the prison's SystmOne electronic medical records, and would have been aware of the man's initial health screen.

30. The investigator discussed with the acting manager of the Compass service that a section of the alcohol pathway form provided during the investigation indicates that if a person scores above 20 and is considered intoxicated on reception, they should be located in the healthcare unit. She explained that, while the form was in circulation, it was not yet officially in use and that aspect of the procedures had not yet been implemented. The reception nurse conducting the initial healthscreen would usually decide on the appropriate location in consultation with the Compass nurse if there were any concerns. No one considered the man needed to be admitted to the healthcare unit; he was able to communicate clearly, was alert and able to walk.

31. An officer completed the man's initial induction documents. He had met the man a number of times before. He was aware of his alcohol problems and noticed that he smelt of alcohol. The man told him that he had seen a doctor but could not yet be given any medication as he had been drinking before he arrived. The officer said that, apart from the smell of alcohol, the man's behaviour gave no indication that he had been drinking. He was cheerful, communicated well and did not seem intoxicated. He was not aware that the man had a history of seizures. He said the Compass nurse would usually indicate when there was a need for more frequent observations. A register is kept to inform the officer on night duty of those that need to be observed and the frequency. After induction, the man was shown to his cell on G wing, landing two. All the cells on this landing are single cell.

32. The evening the man arrived at the prison a nurse was on duty as the Compass team's night nurse on G wing. The nurse explained that his role was to monitor new receptions on the detoxification landing throughout the night. He provided medications, if necessary, and responded to any problems raised by the prisoners during the night. When he arrived for duty, he was given a list of new receptions and what they were prescribed. He had no previous knowledge of the man.

33. During the handover from day staff, the nurse had been told that the man had used alcohol earlier that day but the doctor considered it would be all right for him to be in a cell on his own for that night. (New prisoners would be given a shared cell if there were particular concerns about them.) The nurse recalled being told that the man had a history of seizures when he did not have alcohol, but was aware that he had been drinking alcohol before arriving into custody. The nurse said there was no set frequency of observations for the man. He would decide on the appropriate frequency for each prisoner, but all new receptions would be checked throughout the night. His understanding was that prison officers checked new arrivals hourly on their first night, and he generally checked about four times during the night.

34. The investigator asked the nurse from Compass whether the man's history of seizures and his consumption of a large amount of alcohol earlier that day would have indicated a need for more frequent observations. The nurse said that would depend on his observations when checking the person. If the man appeared to be asleep, he would check that he was actually asleep rather than in distress by looking for movement or getting a verbal response. He said that new arrivals were encouraged to leave their television on to aid observation by the light of the television. If the television was off, he would switch on the cell light which often prompted a verbal response.

35. The nurse could not specifically recall the checks on the man that night but said that, if he had had any concerns, he would have acted on them. He said there was no system to record individual checks or other information. He would record a general comment in the wing observation book at the end of his shift to say how the night had gone.

36. The night officer who conducts the hourly checks does not make entries about individuals but simply places a tick next to the person's name to indicate that a check had been made.

37. An officer was on night duty that evening into the following morning. In a statement, he said that he completed a full roll check on the second landing on G wing at approximately 6.45am that morning. He recalled that the man was watching television and that he saw him move to change the channel. The man was fully clothed, but he did not speak to him.

38. A further officer arrived for duty at 7.30am. The officer said that nothing was mentioned about the man during the morning briefing. At around 8.00am, officers began unlocking prisoners who wished to go out for exercise. When he reached the man's cell, he looked through the observation panel in the door

and saw him lying on the floor with his head pressed up against the back wall. The officer immediately opened the cell door and went inside.

39. The officer could see nothing to indicate that the man had self-harmed. He was unconscious and he could not get a reaction from him. He did not have a radio, so he left the cell and asked a colleague on the landing below to call an emergency code. (He could not recall what code was used, but other officers confirmed this was a code blue which indicates a prisoner is unconscious or having breathing difficulties.) The officer said he did not have a radio so he shouted to his colleague who was a little further down the wing, to call a code blue for G wing, cell 2-12.

40. The officer who didn't have the radio went to assist his colleague and, when he got to the cell, his colleague was administering first aid. He said that his colleague checked for a pulse and loosened the man's clothing. The two officers then tried to lie him straight on the floor and placed a blanket under his head.

41. A nurse was about to start issuing treatments on G wing when she heard the code blue call over her radio shortly after 8.00am. She told the investigator that she responded immediately, taking with her the emergency medical bag. When she arrived at the cell, the man was lying on his back on the floor. On examination, he was not breathing, his lips were cyanosed (blue) and his pupils were fixed and dilated. She could not feel a pulse. After carrying out her observations, she called for further medical assistance and radioed a request for an ambulance. At the time, the process for requesting an ambulance at Hull required a nurse to assess a patient first. The investigator was told that, even if the prisoner was unconscious and therefore would need hospital treatment or assessment, the nurse still had to carry out an assessment before calling an ambulance.

42. The officer who originally discovered the man in his cell and the emergency response nurse attempted cardiopulmonary resuscitation (CPR). A principal officer (PO) arrived and helped give the man oxygen from a cylinder. The nurse then asked the principal officer to give two breaths with the bag valve mask when she requested and CPR continued. The nurse said that she asked for a defibrillator to be brought. There are only two defibrillators at Hull: one in the healthcare wing, which was closest, and one at the far end of the prison.

43. The nurse said that approximately ten minutes after she had arrived, a second nurse joined her. Around five minutes after that, a healthcare officer arrived with the defibrillator (which applies a shock to restart the heart when the machine indicates.) Once attached, the defibrillator indicated that there was no shockable rhythm and CPR continued. A senior healthcare officer arrived to assist, and the four healthcare staff rotated the CPR attempts. In between the cycles of CPR, the staff re-attached the defibrillator approximately three times. Each time, the defibrillator stated that there was no shockable rhythm and instructed the staff to continue CPR. Paramedics arrived at approximately 8.25am and, after a handover from the nursing staff, continued to administer

treatment to the man. He did not respond and at 8.45am the paramedics pronounced him dead.

44. Staff who had been directly involved in the emergency response attended a debrief after the man's death and were offered adequate support. The substance misuse doctor discussed events with his lead clinician. Neither the prison nurse or the nurse from Compass team who had assessed the man the night before, were involved and the nurse from Compass said he thought it would have been helpful. Prison staff spoke to prisoners subject to suicide and self-harm monitoring and offered additional support in case they had been adversely affected by the man's death.

45. An operational manager along with the appointed prison family liaison officer visited the man's sister later that morning and broke the news of her brother's death. There was continued contact with the family, but despite requests being made, the family said that his property was not returned to them for several weeks. In line with national guidance, the prison offered a contribution towards the funeral expenses.

ISSUES

Clinical care

46. The clinical reviewer considers that the man received appropriate care and attention on the evening he arrived and is satisfied that staff made plans to clarify his health issues the following day. However, he considers that it would be helpful for the prison to develop a formal management plan to quantify levels of intoxication and to supplement the clinical observations. He does not consider that this would have affected the outcome for the man.

47. The clinical reviewer says that the communication between members of the different clinical teams was not always ideal, partly because of the geographical separation of the teams as well as separate computer record systems. Prisoners who use Compass services have to give specific consent for their details to be shared with other members of the healthcare team. However, he notes that this reflects confidentiality arrangements in the community.

48. Overall, the clinical reviewer was positive about the man's clinical care at Hull but because of the very short time he was in custody did not feel able to make an assessment of whether it was equivalent to that he would have received in the community.

Location of prisoners withdrawing from alcohol

49. When he arrived at Hull, staff identified that the man required the services of the Compass team. A trained substance misuse nurse and a doctor assessed him, and he was given a cell on a dedicated detoxification landing. Prison Service Instruction (PSI) 45/2010, Integrated Drug Treatment System says:

> '… Local prisons must be able to offer immediate access to clinical services as described in the Clinical Management of Drug Dependence in the Adult Prison Setting (DH 2006) whenever there is a clinical need. This means that all drug or alcohol dependent prisoners arriving in Reception must always be offered immediate admission to a stabilisation unit …'

We are satisfied that the arrangements at Hull met the requirements of the Prison Service Instruction. The man went to a specialist substance misuse unit which had a 24 hour specialist healthcare presence.

50. Although the man was regarded as still under the influence of alcohol when he arrived, the staff who assessed him said that he was able to converse clearly, his speech was not slurred, he was aware of his surroundings, was steady on his feet and was able to walk. The investigator and the clinical reviewer both viewed the route from reception to the wing and were satisfied that, if the man had been in a drunken state, he would not have been able to negotiate the trips unaided.

51. The Compass staff we interviewed were unsure of the circumstances in which a new substance misuser should be placed in healthcare, but said that this would be decided in consultation with the primary care nurses. There was no discussion between the reception nurse and the Compass nurse about the man's location. The acting manager of the Compass service said that the procedures in the alcohol pathway form for assessing whether a prisoner should be monitored in the healthcare centre were not yet in use but the nurse's observations indicated that this was not necessary in this man's case.

52. The reason for the man's seizures was unclear but healthcare staff believed that they occurred when he abstained from alcohol. Therefore, as he had drunk a large amount of alcohol that day, they did not consider the seizures to be of immediate concern. The plan was to find out more about the prescription for his seizures from his community GP. The GP and substance misuse nurse discussed his allocation, noted that no one had raised any concerns and decided that G wing was an appropriate location.

53. Prison Service Order (PSO) 3550, Clinical Services for Substance Misusers, makes it a mandatory requirement for all prisons to have written guidelines for admission to healthcare for those identified as alcohol dependent. Although staff considered that admitting the man to the healthcare unit was unnecessary, this was a matter of individual judgement and not based on supporting guidance or criteria. While we are satisfied that in this man's case appropriate consideration was given to his allocation, and G wing has qualified substance misuse staff, we consider there is a need for clarity about when prisoners withdrawing from alcohol should be admitted to the healthcare unit.

    The Governor and Head of Healthcare should ensure that there are clear criteria to identify when prisoners withdrawing from alcohol should be admitted to the healthcare unit.

Monitoring prisoners withdrawing from alcohol

54. PSO 3550 also says that it is a mandatory requirement for prisons to have written guidelines for the frequency and nature of physical observations. The man was given a cell on the detoxification landing where newly-received prisoners are observed by the duty Compass nurse throughout the night. Staff said that a prison officer also carried out checks on new prisoners.

55. The duty Compass nurse said that there were no prescribed timings for checking prisoners. He decided the frequency of checks, which would usually be around three to four times during the night. There was no system or requirement for him to record these checks. This meant that there is no evidence to confirm his observations of the man during the night. However, no problems were noted and an officer said that the man was seen alive at 6.45am.

56. The clinical reviewer points out that the management of drug and alcohol withdrawal and dependency, is largely dependent on a patient's symptoms and

clinical monitoring. He draws attention to the lack of recorded or structured observations on the detoxification wing.

57. The duty Compass nurse told the investigator that since the man's death, new procedures had been introduced. These require prisoners to be observed at least three times during the night and the observations recorded on the individual's care plan. Nevertheless, we make the following recommendation:

The Governor and Head of Healthcare should ensure that there is clear written guidance setting out the required frequency and purpose of observations for prisoners withdrawing from alcohol and other substances and that all observations are recorded.

Emergency response

58. The officer who found the man went into the cell immediately and summoned help quickly. A nurse, who was already on G wing, responded to the emergency call directly and attended with emergency equipment. Staff promptly attempted resuscitation.

59. We are satisfied that the immediate emergency response was swift. However, it took around 15 minutes before a defibrillator was brought to the cell. There is no indication that the man died from cardiac arrest and that earlier intervention with a defibrillator would have made a difference in his case, but it could in other emergencies. HMP Hull is a large establishment and there is a need to ensure that a defibrillator is brought to an emergency as quickly as possible. The investigator was told that the prison previously had more defibrillators, but they had been withdrawn.

The Governor should ensure there are sufficient defibrillators at appropriate locations in the prison to allow speedy access in an emergency.

60. In previous investigations at Hull, we raised concerns about the requirement for a nurse to assess a prisoner before an emergency ambulance can be requested. This is at odds with the Prison Service policy that internal processes should not obstruct what can be a life saving telephone call. Although the man was unconscious, prison officers who first attended him did not request an ambulance. The call was not made until a nurse attended and requested one.

61. The investigator raised this issue with the Governor, who showed him a copy of a revised Governor's Order, which makes it clear that it is the responsibility of all staff to request an ambulance when they find a prisoner in a life-threatening situation. We welcome this change, and therefore make no further recommendation. .

Support for staff

62. PSI 64/2011 states that post incident care in the form of a “hot debrief” must be held immediately after all the deaths in custody and that all staff directly involved, including healthcare staff, should be invited. These meetings provide support for staff and allow them to identify any immediate issues of concern and to highlight any lessons that might prevent similar incidents. After the man’s death, a debrief meeting was held and all staff immediately involved attended. However, we note that one of the nurses who had not been involved in the emergency response that morning, but who had assessed the man the previous night said that he would have benefited from attending a debrief.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that there are clear criteria to identify when prisoners withdrawing from alcohol should be admitted to the healthcare unit.

HMP Hull accepted this recommendation and have said:

The Compass Offender Recovery Service (CORS)

Have already implemented the following:

Review of 1st night policy
Joint CORS /CHCP communication form
Alcohol pathway / drugs pathway
CORS independent investigation of incident

All staff are up to date with BLS

City Health Care Partnership (CHCP): Planned training

The recommendation has been accepted and the following has been developed and implemented into the pathways between CORS and CHCP

CHCP/ CORS communication form developed to ensure that at first screen the GMS nurse communicates with the CORS nurse regarding their index client and agree an outcome which is clarified prior to the client leaving reception. This information is then recorded on both services healthcare systems to ensure base line information available to all.

An alcohol admission pathway has been developed between CHCP and CORS which clearly indicates the criteria for initial admission onto the inpatients unit and ongoing monitoring requirements by the CORS team during the inpatient assessment stay.

Specialist Training by the CORS team for the GMS inpatients team has been identified as a requirement to support the provision of 24 hour GMS care to CORS clients.

2. The Governor and Head of Healthcare should ensure that there is clear written guidance setting out the required frequency and purpose of observations for prisoners withdrawing from alcohol and other substances and that all observations are recorded.

HMP Hull accepted this recommendation and have said:

The following are in place with The Compass Offender Recovery Service:

SOP for night observations
SOP for general observation
Handover records

Planned action: Audit of policies and SOPs

City Health Care Partnership:

The recommendation has been accepted by CHCP and the following requirements have been agreed with CORS team during the inpatient assessment stay.

Specialist Training by the CORS team for the GMS inpatients team has been identified as a requirement to support the provision of 24 hour GMS care to CORS clients.

An Alcohol admission pathway has been developed between CHCP and CORS which clearly indicates the criteria for initial admission onto the inpatients unit and ongoing monitoring requirements by the

3. The Governor should ensure there are sufficient defibrillators at appropriate locations in the prison to allow speedy access in an emergency.

HMP Hull accepted this recommendation and have said:

This recommendation has been accepted by City Health Care Partnership

To clarify there are currently 3 working defibrillators available within the prison. During the core working day there is a defibrillator with each of the 3 emergency response nurses all positioned at differing points across the prison throughout the working day. At night there is only 1 response nurse with a defibrillator on the Healthcare inpatient unit.