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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man  
at HMP Isle of Wight in January 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 a report of an investigation into the death of a man, a prisoner at HMP Isle of Wight. The man died in January 2012, after a series of long illnesses. He was 67 years old. A post mortem showed that he died from mesothelioma of the lung, a type of cancer. I offer my condolences to the man's family and friends.

The investigation was carried out by one of my investigators and an Assistant Ombudsman. Isle of Wight Primary Care Trust appointed a clinical reviewer to review the man's clinical care. The prison cooperated fully with this investigation. I apologise for the delay in completing this report.

The man had been in prison for some years. By 2010, he reported shortness of breath and collapsed on several occasions. Although he was referred to a respiratory consultant, and had a series of tests, it was not until November 2011 that he received his final diagnosis of mesothelioma. He returned to prison on 15 December 2011 but his health deteriorated quickly, and he died in the prison's inpatient unit in the early hours of a morning in January 2012.

Overall, the investigation has concluded that the man received a good level of care and sympathetic attention to his needs from staff at HMP Isle of Wight. However, initial liaison with his family was not satisfactory and, when he was taken to hospital on 15 November 2011, restraints were used which were not appropriately justified by a risk assessment.

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 arrived at what was then HMP Albany in 2005. He had been convicted of sexual offences. In 2009, a new medical records system was introduced in which it was noted that he suffered from peripheral vascular disease (a disease of the blood vessels outside the heart), cardio pulmonary disease, high blood pressure and recurrent dyspepsia (heartburn). He had also undergone an operation on his brain to reduce tremors in his body in 1989, which left him with problems with his speech.
2. In April 2010, the man was referred to a respiratory consultant at outside hospital. He underwent a series of tests, including X-rays, blood tests and scans. Although some hospital appointments were cancelled, this was usually by the hospital. In November 2011, he received a confirmed diagnosis of mesothelioma (a cancer of the protective linings of the organs) following a biopsy at outside hospital.
3. The man returned to the healthcare inpatient unit at the Albany site, of what was now HMP Isle of Wight, on 15 December. He was given oxygen and saw a palliative care consultant who advised on pain relief and other treatment. He was placed on an end of life care pathway. He died in the early hours of a morning in January 2012.
4. We have found that, overall, the man received a good level of care. However, there was poor communication between the prison and the man's family which meant that they missed a chance to see him when he was in hospital in Southampton. We make a recommendation to improve the communication between the prison and the families of terminally ill prisoners. We make a further recommendation about the use of restraints when the man was taken to hospital for the final time, which we believe was not justified by the risk he presented at that time.

## THE INVESTIGATION PROCESS

5. One of my investigators had conduct of this case. Another investigator visited HMP Isle of Wight on 5 January 2012, on the conducting investigator's behalf, and obtained the man's prison and clinical records. Notices were issued inviting anyone who had any information into the circumstances of the man's death to contact the investigator. No one came forward as a result.
6. Isle of Wight Primary Care Trust (PCT) appointed a clinical reviewer to review the man's clinical care at Albany. A multidisciplinary panel meeting was held at Albany on 16 February 2012 to discuss his care.
7. The investigator contacted Her Majesty's Coroner to inform him of the investigation. We received a copy of the post-mortem report on 23 February 2012.
8. An Assistant Ombudsman visited HMP Isle of Wight on 17 January 2013. He spoke informally to the prison family liaison officer and a prison doctor. He also interviewed the lead pharmacist and a nurse.
9. One of our family liaison officers contacted the man's family to explain the investigation and ask if they had concerns that they would like the investigation to consider. They had a number of concerns, including:
  - Why, given the extent of his symptoms and a diagnosis of asbestosis, there was no further treatment or assessment of his condition, including regular access to oxygen?
  - Whether his medication was withheld and why he once ran out of medication for over a week?
  - Why some of his medical appointments were cancelled?
  - Why they were not told that he had gone to hospital for over two weeks in November/December 2011?
  - Why they were not told that he had moved back to prison from the hospital in Southampton when they had asked to be kept informed? They were concerned about the general standard of liaison with a manager in the prison's healthcare unit.
10. The man's family also asked about an occasion when he collapsed in his cell but staff did not respond until other prisoners alerted them. Unfortunately, we have not been able to establish when this might have been. We have referred to each occasion that he was taken ill in this report.
11. We are sorry that this report is late. The delay was caused by staffing difficulties and workload pressures in our office which caused a backlog of cases which we are striving to clear.

12. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, liaison with his family, his location, whether compassionate release was considered and whether appropriate palliative care was provided.
13. After the publication of the draft report, the man's family provided comments which have led to two factual changes being made. Their other comments reflected that they were upset that he had been restrained when he was very ill, and they remained upset that poor communication had meant that they had not been able to see him before he died.

## **HMP ISLE OF WIGHT**

14. HMP Isle of Wight is an amalgamation of three prisons, Parkhurst, Camp Hill and Albany. The man was at the Albany site, which holds up to 567 sex offenders and vulnerable prisoners in five cell blocks.
15. Health services at HMP Isle of Wight are commissioned and provided by the Isle of Wight Primary Care Trust (PCT). An inpatient healthcare unit (IHU) at the Albany site caters for prisoners with a wide range of mental health, general medical, rehabilitative and health-related respite needs.

## **HM Inspector of Prisons (HMIP)**

16. HMIP conducted an announced full follow-up inspection of HMP Isle of Wight in May 2012. They found that health services had improved considerably from their previous inspection, although there were some delays in accessing primary care services for prisoners at Albany. Inspectors also found that there were good care arrangements for men with palliative care needs.
17. The inspection found that prisoners with chronic (long term) diseases were reviewed regularly and there were suitable nurse-led clinics for prisoners with respiratory diseases.

## **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 recent IMB annual report for HMP Isle of Wight noted that the opening of the inpatient healthcare unit had reduced the number of prisoners staying as inpatients in outside hospital. They also noted that the ageing population, particularly at the Albany site, had led to increased waiting lists for some health services.

## **Previous deaths at HMP Isle of Wight (Albany)**

19. We have investigated a number of previous deaths at the Albany site of HMP Isle of Wight, most of which were of older prisoners. Many of the men who died at the Albany site had serious medical conditions and a number had been diagnosed with cancer. The man was the sixth man to die at the Albany site since January 2011 and there have been a further eight deaths since.

## ISSUES

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

20. On 20 December 2009, it was noted in the man's medical records that he suffered from peripheral vascular disease (a disease of the blood vessels outside the heart), cardio pulmonary disease, high blood pressure and recurrent dyspepsia (heartburn). In 1989, he had undergone an operation on his brain to reduce tremors in his body which left him with speech problems.
21. The man was taken ill in the gym on 20 January 2010, where he vomited. He also said that he had not slept for a couple of nights. He was taken back to his residential wing, but did not attend a GP appointment the next day. He saw a prison doctor on 28 January and said that his symptoms had improved.
22. On 6 April 2010, the doctor examined the man as he was short of breath. The doctor described his chest as sounding "bubbly", and gave him oxygen, which improved his oxygen blood saturation levels from 95% to 98%. He went to outside hospital by ambulance but it not clear from the prison medical record what treatment he received.
23. An appointment was made for 13 April 2010, for the man to see the respiratory consultant at outside hospital, but the appointment was cancelled by the hospital and re-arranged. He attended on 6 June and the respiratory consultant noted in a letter to the prison healthcare staff that the man's appointment had suffered from administrative delays. He noted that the man had told him that he was suffering with breathing difficulties and they were "as bad as ever". He had a chest X-ray and, because of his history of having a productive cough, being an ex-smoker and being exposed to asbestos at work, the respiratory consultant organised some blood tests, a CT scan, with a bronchoscopy to follow once the CT scan was completed. He explained to the man that he might have tuberculosis, bronchiectasis (an irreversible widening of the bronchi in the lungs) or lung cancer. He prescribed tiotropium bromide, a drug taken in an inhaler to reduce breathing problems.
24. The man saw a prison GP on 30 September. He told him that he had not benefited from his medication. The GP noted in the prison medical record that the man might have chronic obstructive pulmonary disease (COPD) and referred him to hospital for an X-ray and to attend the rapid access chest pain clinic.
25. The respiratory consultant saw the man again on 5 October. He thought that the man might have cancer, but a CT scan did not reveal any evidence of pulmonary masses or metastases (the spread of cancer from one organ to another). A prison GP noted in the prison medical record on 1 November that a chest X-ray had similarly not shown any evidence of active lung disease.

26. On 5 November, the man saw another prison GP, complaining of shortness of breath. The GP noted a diagnosis of asbestosis. As he already had an appointment at hospital on 21 January 2011, no fresh appointment was made. However, this was brought forward to 31 December.
27. On 21 December in the afternoon, the man suffered a further bout of chest pain, which he said radiated down his left arm. He was taken to the healthcare unit and given 300mg aspirin and oxygen. An ECG was taken which showed no changes. However, the man's pain did not improve so an emergency ambulance was called at 3.27pm. He stayed the night in hospital and was discharged the next day to the prison's inpatient unit. While he was there, he had a further episode of shortness of breath in the shower. It was noted in the prison medical record that he quickly recovered and did not require a nebuliser or oxygen therapy. He was diagnosed with angina and monitored before returning to his wing. As part of his care plan, he was to be offered a ventolin nebuliser, and assessed further to see if he needed oxygen therapy (it is not clear if this assessment took place).
28. The man did not attend hospital on 31 December. According to the prison medical record, he "slid down the wall" while waiting in reception and was unable to get up by himself. He then decided not to attend hospital and signed a disclaimer. The appointment was rebooked for 8 February 2011. After this appointment, the hospital wrote to Albany giving a diagnosis of COPD and benign asbestos-related pleural (lung) disease. On 20 March, the man fell in the corridor. Although he was advised to wait where he was for an ambulance, he decided to get up and the ambulance was cancelled. A prison GP saw him later that day and prescribed an inhaler.
29. On 4 April 2011, the man complained of severe pain in his loins and shortness of breath. As staff were unable to obtain his blood pressure, he was given oxygen and taken to hospital for observation. He returned the same day. An appointment for the respiratory unit for 11 April was cancelled by the hospital and rebooked for 7 June, when he had an assessment of the level of his COPD.
30. On 14 October, the man had another angina attack. He stayed in the prison's inpatient unit for three days before being discharged to the wing. It was noted on 16 October that he had not needed any oxygen. A prison GP saw the man again on 18 October when he said he had been more short of breath in the previous four weeks than he had been before, and that his inhaler did not help. The GP referred him for a chest X-ray, and thought he was probably suffering from heart failure. The man preferred to stay on the wing rather than be admitted to the inpatient unit.
31. The X-ray results returned the next day. A doctor from outside hospital noted that there was 5cm mass in the right upper zone of the man's lung. He questioned whether the man had mesothelioma (a cancer of the

protective linings of organs, often associated with exposure to asbestos). The doctor recommended an urgent referral to the chest clinic. An appointment was booked for 31 October.

32. However, on 31 October, the man was again short of breath and a prison GP referred him immediately to hospital so that fluid could be drained from his chest. He returned to the prison on 4 November, but was re-admitted to hospital on 10 November because he was short of breath and was in pain. He returned to the prison that evening after being prescribed tramadol for his pain. He said that he wanted to return to his cell on the wing.
33. By 15 November, wing staff were again concerned about the man, who had run out of the tramadol the hospital had prescribed. A prison GP saw him the next morning and sent him to outside hospital for an urgent X-ray and to assess his pain relief. He was transferred to a further outside hospital on 22 November and had a lung biopsy on 25 November. By 3 December (the exact date is not clear from his medical record), he had returned to the local hospital.
34. On 15 December, a nurse from the prison visited the man at outside hospital. He had been told that he had a mesothelioma.
35. The clinical review panel considered whether the timing of the man's final diagnosis was appropriate. They noted that he had presented with symptoms such as shortness of breath since June 2010 and that the conclusive diagnosis of mesothelioma was not given till December 2011. However, in that time, he had both chest X-rays and CT scans which did not reveal any evidence of mesothelioma, and that he was seen appropriately by a hospital consultant during this period. We are therefore satisfied that there was no evident delay in the man being diagnosed with a terminal illness.

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

36. The man was informed of his confirmed diagnosis in hospital, once the results of the lung biopsy of 25 November were received. A prison GP had previously told him, on 19 October, that an X-ray had shown possible mesothelioma. The clinical review panel found that the man had an informed conversation with the consultant oncologist about his diagnosis and treatment options when the diagnosis was confirmed. He was informed that his prognosis was very poor and that he might receive chemotherapy but this would not cure him. The man did not have chemotherapy and died before a further appointment with the oncologist in January.

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

37. The man missed several hospital appointments in December 2010 and November 2011. The clinical review panel have reviewed the causes of the cancellation of these appointments and have commented that “there is no evidence that any appointments were cancelled or rearranged for prison operational reasons and no evidence that any were [cancelled] for other than NHS operational reasons.” The man also decided not to attend hospital on 31 December 2011, when he was unwell in the prison reception. He also chose not to attend several appointments with the prison GPs. He was due to have a further appointment with the oncologist in January, but died before this could take place.

### **The man’s medication and oxygen therapy**

38. The man’s family were concerned that some of his medication might have been withheld and that, on one occasion, his medication ran out. When the Assistant Ombudsman examined the man’s prison medical records, he noted that, on 6 May 2010, a prison GP had recorded that the man had run out of lisinopril (for blood pressure) and quinine (often used for leg cramps), and was down to the last five doses simvastatin (for high cholesterol) and propranolol (a beta-blocker). The prescriptions were re-issued the following day.
39. The lead pharmacist at Albany confirmed that there had been a delay in issuing these prescriptions, which the man should have received on 4 May. She explained that the monitoring procedure has now changed, and that the pharmacy, not the nursing staff, now monitor prescriptions, using a different computer system. This has eliminated mistakes of this type.
40. The lead pharmacist was asked to check the record to see if there was any delay in issuing medication around 18 January 2011, when a manager in the healthcare unit noted in the prison medical record that the man thought that there were delays in receiving his medication. The lead pharmacist confirmed that medication had been issued as prescribed and that there was no gap in his medication. On 15 November, the man was noted to have finished a supply of tramadol prescribed by the hospital. He was then assessed for pain relief at hospital the next day.
41. The man’s family were concerned that he was not given supplies of oxygen when he needed it. Oxygen is fully available in the inpatient healthcare unit where it is piped through the walls. (He was in such a room with an oxygen supply when he returned to the inpatient unit on 16 December). A nurse said that oxygen was taken to the wing whenever the man needed it, but she said that he did not need it regularly as his inhalers were normally sufficient. It is clear from the prison medical record that a nurse fully discussed the provision of oxygen to the man when she saw him in hospital on 15 December 2011.

42. The clinical review panel have not raised any concerns about the man's supply of medication or oxygen. Although, on one occasion, he received his medication late, we are satisfied that this issue has now been addressed and that he did not suffer any long-term consequences. We are also satisfied that oxygen was available for him when it was required

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

43. The man's family said they were very disappointed about how they were treated by the prison before his death. They felt that they had not been given a chance to say goodbye to their relative, as the prison did nothing to help them see him before he died.
44. His family said that, when their relative was taken to hospital in November 2011, they were not informed. They were concerned as they had not heard from him for two weeks. It was only when his niece called the prison on 29 November that they were told that he was in hospital. This is the first recorded contact with his family. This was two weeks after he was taken to hospital on 16 November and a week after he had been transferred to hospital in Southampton. Prison Rule 22(1) states:

'Notification of illness or death

'22. - (1) 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.'

45. It is apparent that the man was seriously ill when he went to hospital on 16 November 2011. This should have prompted the prison to contact his next of kin, which they did not do.
46. When the man's niece spoke to healthcare staff at the end of November she was told that he had been taken to outside hospital, but that she could be given no further details because of patient confidentiality. However, on 18 January 2011, the man had given written permission that his family could discuss his health matters. After this issue was resolved, the man's niece spoke to a manager in the healthcare unit about his likely prognosis. She said that they hoped to visit him in Southampton where they had family. She said she asked the healthcare manager to let them know if their relative moved back to the Isle of Wight. However, while they were making arrangements to visit him in Southampton, he returned to the Isle of Wight and his family was not informed. The man's niece said the healthcare manager then denied saying he would inform her of the move and, in any case, it was not his job to do so.
47. The healthcare manager left the Prison Service early in 2012, and we have not been able to speak to him. He made two entries in the prison

medical record which would appear to correspond to the conversations he had with the man's niece. The first of these was on 29 November 2011, when he noted that the man's niece had called as his sister had died and that he would like the prison to tell him. The healthcare manager noted that healthcare staff and the chaplain had been informed. There were no other details of the conversation noted.

48. On 6 December, the healthcare manager made the following entry:

“Patient consented to sharing of information. Contact by phone to [man's niece] as expected to be informed of [man's] return to [outside hospital] informed not happy as expected me to phone explained I had been away and this was first opportunity and needed to go through the prison for this information has a lot of family pressure and illness and conversation was not being understood but understand why is listening to her uncle re reports of health which do not always match what is in his notes confusing for the family and difficult to explain to her.”

49. Although we have not been able to speak to the healthcare manager, it seems there was some breakdown in communication. The move back to the Isle of Wight was not a decision by the prison but as a result of the hospital deciding to discharge the man. This does not appear to have been communicated well. A nurse explained that when prisoners transferred to hospital, prison staff dealt with the family, not healthcare staff. She said that sometimes this was difficult as it meant that families did not receive information first hand.
50. Current Prison Service guidance requires prisons to ensure that there are arrangements 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 and that it is good practice for a log of contact with the family to be kept. Before the man returned to the Albany site of the prison from hospital, a family liaison officer was appointed on 12 December. Had a trained family liaison officer been appointed at an earlier stage some of the communication difficulties might have been avoided. The family liaison officer spoke to the man's sister on 16 December at the man's request to inform her of his condition. After his condition deteriorated on 31 December, the family liaison officer spoke to his niece, explained about his condition and asked whether she would like her to go and sit with him, which she did. The Chaplain also saw the man. His niece asked that the family liaison officer tell her when her uncle died. As the man died early on New Years' Day, she called his niece later that morning.
51. The family liaison officer returned the man's property to his family on 13 January. The prison contributed to the costs of the funeral, which the family liaison officer attended. A memorial service was also held by the prison on 31 January 2012.

52. We are satisfied that later family liaison was appropriate but because of the earlier difficulties that his family had getting information about their relative we make the following recommendation:

**The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible and that there are appropriate and effective arrangements to enable families to obtain information about them.**

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

53. During the latter part of 2011, the man spent several periods in hospital. On some of the occasions, when he was released, he chose to return to his residential wing rather than stay in the prison's inpatient unit. Before his final return to the Albany site of HMP Isle of Wight on 16 December 2011, a nurse visited him in hospital to discuss his concerns about living in the inpatient unit and explained that he would not be able to manage on the wing as he would not receive the continuous oxygen therapy or the nursing input he required. A manager in the healthcare unit agreed that he could keep his pet budgerigar and some other possessions with him in the inpatient unit, which was one of the reasons he had been reluctant to move from the wing.
54. We are satisfied that the decisions about the man's location in the prison were made appropriately and with his best interests in mind. Allowing him to have his pet budgerigar and other possessions with him was a sensitive decision which allowed the man some comfort in his final days.

### **Early release on compassionate grounds**

55. When the family liaison officer spoke to the man's niece on 20 December, his niece said that they did not want him to die in prison. The family liaison officer said that she would follow up an application for compassionate release and, on 22 December, she established that an application had gone to the Head of the Offender Management Unit, for his comments. A prison GP told the clinical review panel that the appropriate medical paperwork had been completed, but that the man's condition deteriorated very rapidly and that the process could not be completed before he died. We accept that, unfortunately, there was little time for the man's application to be progressed before his death.

### **Palliative care plans and pain relief**

56. A consultant in palliative care from a hospice saw the man on 29 December 2011, after a prison GP had asked him to visit. The consultant recommended that he be given lorazepam for dyspnoea, an additional laxative and gabapentin (for additional pain relief; he had been given morphine-based pain relief the day before).

57. After his return from outside hospital on 16 December, a care plan was instigated, which included monitoring his pain, providing emotional support and ensuring personal hygiene needs were met. On 31 December at 7.00pm, a nurse noted in the prison medical record that staff had commenced the Liverpool Care Pathway (LCP). (The LCP is used by the NHS as a way of delivering end-of-life care.) A syringe driver, which is used to administer medication more effectively, was sourced from the hospital and used to give him pain-killing drugs.
58. The clinical review panel were satisfied that appropriate pain relief and palliative care measures were in place, and that there was effective liaison with the hospice.

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

59. The Prison Service has a duty to protect the public when escorting prisoners to hospital, while treating prisoners with humanity and dignity. The level of restraints used should be appropriate to all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public, the prisoner's category and which also takes into account factors such as the prisoner's health and mobility.
60. A judgment 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 judgment indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. The judgment also required that risks during stays in hospital needed to be assessed separately from travel to and from prison and should be reviewed regularly during a hospital stay or when circumstances changed.
61. The man was in outside hospital between 22 November and 9 December 2011. He was then transferred to a further outside hospital, and returned to the local hospital on 9 December. During this time, he was accompanied by prison officers and restrained using an escort chain. Risk assessments completed during this period concluded that he presented a medium risk of escape and reoffending, although it was noted that his mobility was restricted by his use of an oxygen tank and a wheelchair.
62. On 14 December, the man's escort chain was removed as a result of his deteriorating health. The risk assessment form noted that the escorting officers were to assess him in the event that an improvement in his condition led to restraints being necessary. He remained unrestrained for the last two days of his stay in hospital and returned to the prison on 16 December.
63. While we are pleased that the risk assessment was reviewed when the man was in hospital, we believe that the original assessment was

inappropriate. He was clearly very ill by this time, and used a wheelchair and, often, oxygen. In these circumstances, it is difficult to see how his risk of escape and harm to others could not have been managed by two officers without the need for physical restraints. We make the following recommendation:

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

## RECOMMENDATIONS

1. The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible and that there are appropriate and effective arrangements to enable families to obtain information about them.

NOMS accepted the recommendation and commented:

“The Health Care Manager will inform the Safer Custody Team / FLO Coordinator of any seriously ill prisoner that will require an FLO to be allocated in order to keep family fully informed. Current checks confirm that contact with families is taking place and is common practice unless alternative arrangements have been agreed with the Next of Kin.”

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

NOMS accepted the recommendation and commented:

“The Head of Security has reviewed escort risk assessments to enhance the medical contribution section to better inform the decision making process in relation to the appropriateness of restraints. Information has been provided to all Operational Managers to assist them in making decisions with regard to the use of restraints for escorts and bed watches. Additionally this has been added into the Local Security Strategy and a management Check system is now in place.”