



**Investigation into the circumstances surrounding the
death of a man
at HMP Isle of Wight in September 2011**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

August 2012

This is the report of the investigation into the circumstances surrounding the death of a man who died in September 2011. He was in the custody of HMP Isle of Wight when he passed away. He was 88 years old.

The loss of any family member can be distressing, but especially so when they are in custody. I offer my sincere condolences to the man's family and friends.

The man arrived at the Isle of Wight on 7 July, after being sentenced to serve 11 years in prison. He had a number of pre-existing medical conditions which were stable and he continued to receive his usual medication. He was seen regularly by the doctors and nurses in prison healthcare.

At approximately 11.40am on a day in September, the man was found unresponsive in his cell by a fellow prisoner. The man received immediate attention from medical staff, but after a thorough examination, a doctor pronounced him dead at around 11.45am. The post mortem later confirmed the cause of death was hypertensive and ischaemic heart disease.

The investigation was conducted by one of my investigators. A clinical review of the man's healthcare was commissioned with the Isle of Wight Primary Care Trust (PCT), who appointed a clinical reviewer to conduct the review. Additionally, a review panel considered the health related circumstances surrounding the man's death, which was attended by my investigator and the clinical reviewer. The panel were of the opinion that the man's care was equivalent to that he would have received in the community. However, they also made recommendations concerning the transfer of medical information about prisoners between prisons and about a GP conducting the second healthscreen interview when a prisoner has a complex medical history. I endorse both these recommendations.

Two further issues have previously been reported on following investigations into deaths in custody at Albany. The first concerns resuscitation attempts. It was clear to staff who found the man that he was dead, and they did not attempt to resuscitate him. However, the review panel thought that further clarification for staff on the issue would be of benefit, and I repeat their recommendation here.

The second issue related to the sanitation system in use on several wings at Albany. A recommendation was made, in a report received by the prison shortly before the man's death, that the Governor should ensure that prisoners who are unable to use the sanitation system should not be housed on those wings. The man clearly fell into that category, as he struggled with his mobility and his medication meant he needed to use the toilet frequently. I have repeated the recommendation, and join with both Independent Monitoring Board and Chief Inspector of Prisons in questioning whether the use of such a system is appropriate in a modern prison system.

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.

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Prisons and Probation Ombudsman

August 2012

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SUMMARY

1. When he was imprisoned for 11 years in June 2011, the man, who was 87 years old, had pre-existing medical conditions including Meniere's disease (a disorder affecting hearing and balance), hypertension (high blood pressure), an irregular heartbeat and high cholesterol. He also used a walking stick. These conditions were stable and he continued to receive his usual medication.
2. During routine blood tests at HMP Bristol in early July, it was discovered that the man also had moderately severe iron deficiency anaemia. This abnormal test result arrived at Bristol shortly after he had been transferred to HMP Isle of Wight on 7 July, where his anaemia was again diagnosed and he was prescribed iron tablets.
3. On reception at Isle of Wight (the man was located at the Albany site), he reported to the nurse that his Meniere's disease was worsening. He was also placed on the hypertension waiting list. Three days later, he collapsed in a corridor, but after being seen by a nurse he was able to sit up and walk back to his cell. He was advised to see a doctor.
4. The doctor noted his past history of tachyarrhythmias (increased frequency of heart beats), and ordered an electrocardiogram (ECG) which was performed the same day. The ECG results indicated possible ischaemic heart disease and blood tests were requested. On 4 August, it was noted on the man's medical record that he had ischaemic heart disease and further blood tests were arranged.
5. The man suffered from diarrhoea because of the iron tablets he was taking. He was prescribed an alternative, but he still had problems. The dosage was reduced to once daily by the end of August.
6. Following a routine blood sample taken around 10.00am on a day in September, the man returned to his cell. At approximately 11.40am, another prisoner entered his cell to wake him but found no response or movement. He informed a prison officer, who found the man cold to touch. A doctor and two nurses attended immediately, but the man had already passed away and he was declared dead by the doctor following a thorough examination.
7. We make four recommendations. These relate to the forwarding of medical test results, the secondary healthscreen being undertaken by a GP, resuscitation and the use of the sanitation system.

THE INVESTIGATION PROCESS

8. This office was notified of the man's death on 7 September. Notices announcing the investigation were supplied and displayed by the prison to staff and prisoners, who were invited to contribute any relevant information. No prisoners or staff made contact.
9. All the relevant prison records relating to the man were studied by the investigator. They included his main prison record, medical records and statements made by staff. We apologise for the slight delay in issuing this report, which is due to the late receipt of the clinical review and workload pressures in this office.
10. The Ombudsman's Senior Family Liaison Officer contacted the man's family. This gave them the opportunity to discuss the purpose of the investigation and raise any concerns or questions that they wanted to be addressed. They chose not to raise any concerns at that time, but will receive a copy of this report.
11. A clinical review of the man's healthcare was commissioned with the Isle of Wight Primary Care Trust (PCT). A clinical reviewer led the review. Additionally, a review panel considered the health related circumstances surrounding the man's death. We received the clinical review in January 2012.
12. Her Majesty's Coroner was contacted by the investigator to inform him of the nature and scope of this investigation, and to request a copy of the post mortem report. Upon completion, a copy of this report will be sent to the Coroner to assist his enquiries into the man's death.
13. The investigator visited HMP Isle of Wight (Albany) on 18 October, to familiarise himself with the general environment of the prison. He visited the man's cell, spoke with members of staff and prisoners, and was shown how the electronic night sanitation system is used.
14. A clinical panel review meeting was held on 8 December, attended by the investigator, the clinical reviewer, the man's prison doctor, the healthcare manager, the acting deputy governor of the prison, head of prison healthcare and other members of Isle of Wight NHS PCT. The healthcare of the man was discussed and specific issues raised by the investigator and the clinical reviewer were considered.
15. The man's wife received a copy of the draft report as part of the consultation process and provided a written response to the findings of the investigation. She raised a number of issues and suggested that a second screening should have taken place once it was identified the man was hypertensive. We have made a recommendation about this concern within the report. The man's wife was also very distressed to learn about sanitation issues experienced by her husband and again we have made a recommendation about this issue. We are grateful to the man's wife for the time she has taken to consider the report

and for the feedback she felt able to share. It was felt, however, that some of the issues raised would be more appropriately addressed outside of this report.

HMP ISLE OF WIGHT – ALBANY

16. HMP Isle of Wight was formed on April 2009, by the merging of three former establishments, HMP Albany, HMP Camp Hill and HMP Parkhurst. The prison accommodates approximately 1,700 prisoners on the three sites, with each site having its own Director who reports to the Governor.
17. Albany consists of five wings located off one main corridor, almost identical in design and which hold 94 to 96 prisoners in single cells. Each wing contains four floors, each with three spurs of eight cells. These prisoners have access to electronic night sanitation (when the cell door unlocks for a limited time to allow the prisoner to go to the toilet). A modern unit of two more wings was opened in May 2003, consisting of single cell accommodation with en-suite facilities, housing up to 80.
18. Albany is a category B training prison with an integrated population of vulnerable sex offenders and mainstream prisoners, and offers a varied regime with education and several offending behaviour programmes. The average age of its population is high compared to most prisons. Albany has an operational capacity of 567.
19. Health services at Isle of Wight are commissioned and provided by the Isle of Wight Primary Care Trust (PCT). A new Inpatient Healthcare Unit was opened in October 2009 and is situated on the Albany site. It has 12 beds and caters for prisoners with a wide range of mental health, general medical, rehabilitative and health-related respite needs, including acute care and recovery post-discharge from emergency treatment, or elective secondary care and treatment at the local hospital or elsewhere.

Previous deaths at Albany

20. There have been 31 previous deaths at Albany since 2004, with 24 being from natural causes. In several of the reports into these deaths, we have made recommendations about resuscitation. However, in all of these cases, the prisoner had been suffering from a terminal illness and the circumstances of their deaths do not reflect those of this man.
21. However, in another report which was issued to Albany in draft form in June 2011, we made a recommendation about the night sanitation system. The recommendation said:

“The Governor should ensure that if a prisoner is unable to easily use the night sanitation system they should not remain on the wing.”

NOMS accepted this recommendation, and said that “this will now form part of the local policy”.

Her Majesty's Inspectorate of Prisons

22. HM Chief Inspector of Prisons made an unannounced inspection of HMP Isle of Wight between 4 and 15 October 2010. In his introduction of his report dated January 2011, he wrote

“Accommodation was generally satisfactory, with the glaring exception of Albany’s poorly functioning automatic night sanitation arrangements, which remained unacceptable and degrading.”

Independent Monitoring Board (IMB)

23. Each prison is monitored by an IMB, members of which are drawn from the local community. They have full access to prisoners and every part of the establishment. In their latest annual report covering the period 1 January to 31 December 2010, the IMB state,

“Although the Night Sanitation system has been much improved this year, it fails from time to time, leaving prisoners with the only alternative of ‘mop and slop.’ As Albany site houses quite an older population, many need the toilet more than once during the night, creating even more problems. It is about time that this electronic system is put right once and for all. Just one breakdown is one too many.”

KEY FINDINGS

24. At a crown court on 1 June 2011, the man was sentenced to serve 11 years imprisonment for serious offences. He was sent to HMP Bristol and arrived there at 5.10pm the same day. During his induction he was seen by a nurse who noted that he was 87 years old and had Meniere's disease (a disorder of the inner ear that can affect hearing and balance). He was deaf in his right ear, partially deaf in his left ear, wore glasses, walked with the aid of a walking stick and suffered from breathlessness and a hernia.
25. That evening, a doctor prescribed the man his usual medication, omeprazole (suppresses gastric acid secretion), bendroflumethiazide (used to treat hypertension, high blood pressure), amiodarone (used for irregular heart beat), simvastatin (used to control elevated cholesterol), thyroxine (for hypothyroidism, often called an underactive thyroid and which causes many of the body's functions to slow down), and aspirin (analgesic and anti-inflammatory).
26. Two days later he was referred by the doctor to the ear, nose and throat service about an old perforated right ear drum and a week later he was given some itch relief cream when he complained of itchy dry skin. The rash was gone by 15 June.
27. On 5 July, the man had routine blood tests. The results of these tests were, eGFR (tells how much kidney function you have) 55, Hb (haemoglobin is a protein in red blood cells that carries oxygen) 9.1, ferritin (a protein found inside cells that store iron so your body can use it later) 21, glucose (glucose level is the amount of glucose (sugar) present in the blood) 8.2. These results were abnormal, showing an iron deficiency. By the time they arrived back at Bristol, the man had been transferred to HMP Isle of Wight.
28. Leaving Bristol on 6 July, the man stayed at HMP Winchester overnight and arrived at HMP Isle of Wight (Albany) on 7 July. At his reception screening he was seen by a nurse who noted that he had Meniere's disease, which he reported was worsening, and that he used a walking stick. The following day at his second screening, the nurse put him on the hypertension waiting list, and recorded the man's pulse but not his blood pressure. The man was not referred to a doctor. He was allocated a single cell on A wing.
29. When the man collapsed in the corridor on 10 July, he was seen by a nurse who, having checked the man was ok and had no injuries, checked his observations (blood pressure and oxygen saturation, a measure of how much oxygen is in the blood). The man then sat himself up and walked back to his cell. He was advised to see a doctor to review his Meniere's disease.
30. The following day the man was seen by a nurse. He told the nurse he had dizzy spells on and off for a long time, with his history of Meniere's disease. He stated he felt ok immediately following them and they had not increased in frequency. The nurse asked him to keep a record of them.

31. Nine days later, on 20 July, the man had a further dizzy spell in his cell where he bumped his head and bruised his right forearm. He was seen by a nurse who found the man's blood pressure to be 167/67 and advised that this may be postural hypotension (an abnormal decrease in blood pressure when a person stands up, which may lead to fainting).
32. A doctor saw the man regarding his dizziness on 25 July. The doctor noted the past history of tachyarrhythmias and that he was taking amiodarone for this. The doctor ordered an ECG (electrocardiogram, a test which measures electrical activity in the heart) which was performed the same day. The next day the doctor reviewed the ECG and noted that previous blood results were not to be seen in the man's records so he ordered new blood tests.
33. The blood tests were done on 4 August, and were noted as Egfr 71, fasting glucose 5.0, haemoglobin 9.2. When a doctor read them, he noted that the full blood count showed microcytic (small red blood cells) anaemia (iron deficiency) and arranged further blood tests. On 10 August, the man's ferritin was 13.0 (which is low) and the next day the doctor prescribed ferrous sulphate (iron tablets) 200mg one tablet three times a day.
34. Following three negative checks for blood in the man's stools on 16 August, he was seen by a doctor on 25 August. The man told the doctor he was suffering with diarrhoea on the iron tablets so the doctor reduced the dosage to one tablet every day. The doctor examined the man's chest and abdomen, found them to be normal and requested his urine be tested for blood and bad proteins.
35. A nurse saw the man on the wing on 29 August. He told the nurse he had not been taking his iron tablets because he could not tolerate them, he felt unwell and still had loose bowels. A doctor then reviewed him and prescribed an alternative form of iron tablets, ferrous fumarate 210mg one tablet three times a day.
36. On 1 September, the man was formally warned for exceeding the permitted time of seven minutes allowed out of his cell on day sanitation. On A wing there are no toilets in the cells and prisoners have use of either a lidded bucket or access to electronic day/night sanitation (this is when the cell door unlocks for a limited time to allow the prisoner to go to the toilet).
37. At approximately 10.00am on a day in September, the man attended a routine appointment for blood tests in Albany's healthcare centre. He was seen by a nurse. The man told the nurse he was still troubled by his upset bowels and problems accessing the toilet. The nurse spoke to a doctor about this and the doctor agreed that the man needed 24 hour access to a toilet and he added him to the waiting list for F or G wing.
38. After his appointment, the man returned to A wing and went straight to his cell where he informed another prisoner that he was going to lie down and get some rest. It was un-lock period and all cell doors were open. At 11.40am, a

prisoner entered the man's cell and found him unconscious and unresponsive. He immediately alerted an officer, who entered the cell.

39. The officer could not gain a response from the man and on checking him found him cold to the touch, not breathing and with no signs of life. In his statement the officer said, "I immediately thought he was deceased and I raised the alarm over the prison radio system." The officer called a code blue (person not breathing) on his radio, to summon medical assistance.
40. Two nurses responded to the emergency call and arrived within a minute, closely followed by a doctor. The man was rolled onto his back and examined. Checked on both sides, he was found to be very cold and his limbs were difficult to move. Cardio pulmonary resuscitation (CPR) was not attempted. The doctor pronounced that the man had died at 11.45am.
41. Shortly after the man's death, the prison activated its death in custody contingency plan. The Police, the Governor, the Coroner, the IMB and the PPO were informed. A hot debrief (a meeting to ensure that any critical issues are discussed, and to offer support to staff) was held and chaired by the Governor. The police visited the prison shortly after noon. They found no suspicious circumstances. Family liaison officers from HMP Bristol visited the man's wife at her home address during the afternoon, to inform her of her husband's death.
42. A prison family liaison officer was appointed and kept in close contact with the man's wife, visiting her at her home where she was offered advice and support. Notices to inform prisoners and staff of the man's passing were issued throughout the prison. Prisoners and staff who knew him were spoken to and also offered support.
43. A Home Office pathologist carried out a post mortem examination on the man a few days after his death. At the external examination, he found that there were no features to suggest that the man had been the victim of attack or restraint by another person. Toxicological analysis for drugs and poisons was negative. On internal examination, he found that the man's heart muscle had become greatly enlarged in response to a sustained increase in systemic blood pressure (hypertensive heart disease).
44. In addition, the pathologist found degenerative narrowing of the coronary arteries supplying the heart (coronary atheroma). This had inflicted severe damage on the heart muscle (ischaemic heart disease), rendering it still more liable to a sudden defect in rhythm or blood supply. The man's cause of death was recorded as hypertensive and ischaemic heart disease. In his report, the pathologist commented, "These two disease processes, which are commonly found together and which are interdependent, can bring about unexpected collapse or death at any time."
45. A memorial service was held at the prison, attended by friends and staff, the man's funeral was held on 28 September, with the funeral costs being met by the prison.

ISSUES

Clinical Care

46. The man was seen regularly by the GPs and nurses in prison healthcare. His symptoms were investigated. However, whilst at HMP Bristol, the man had blood tests which later revealed that he had moderately severe iron deficiency anaemia. Unfortunately, by the time these results were received the man had already been transferred to HMP Isle of Wight. The results were filed as scanned images rather than as numeric values, making it more difficult for others to find the results. There was no evidence found in the man's medical record by the clinical reviewer that these abnormal results were flagged or marked as being in need of attention.
47. The tests were repeated at HMP Isle of Wight, and the findings of anaemia were confirmed. The delay whilst these tests were repeated was unfortunate, but was not material. The man collapsed unexpectedly due to longstanding damage to his heart from hypertension. However, in another case, this delay might have adversely impacted on a prisoner's care. The clinical reviewer makes the following recommendation to prison healthcare teams at Bristol and the Isle of Wight. We endorse the recommendation, which we will also share with the Offender Health team at the Department of Health so they can consider whether to share this recommendation more widely.

The Heads of Healthcare at Bristol and the Isle of Wight should ensure that, when abnormal results are received after a prisoner leaves a particular site, every attempt is made to highlight those results and forward them to their new site, or GP, if they have left custody.

48. On arrival at HMP Isle of Wight, the man had two reception health screens. At his first reception screening he was seen by a nurse who noted his history of Meniere's disease and that he used a walking stick. The following day at his second screening, the nurse put him on the hypertension waiting list and recorded the man's pulse, but his blood pressure was not recorded. He was not referred to a doctor. Given the man's extensive medical history, the second healthscreen would have been an ideal history for him to be reviewed by a GP. The clinical review panel make the following recommendation, which we endorse:

The Head of Healthcare should ensure that where new prisoners have significant medical histories, or are prescribed regular medication, second reception health screens should be by a GP.

49. It is clear that no attempt at resuscitation was made when the man was found lifeless on his bed. The officers made an emergency call for help, and two nurses and a GP attended. The officer did not start CPR and on arrival, the healthcare staff agreed with this decision and he was certified deceased. The GP was called promptly and, given the man's age and general health, resuscitation would be very unlikely to have been successful.

50. The review panel agreed that this was an appropriate decision in this situation. However, the default position is to attempt CPR unless it is felt to be inappropriate, or a Do Not Resuscitate form had been completed. The DNR form would usually involve a discussion with and agreement of the patient, though it was acknowledged that in exceptional cases, where such a discussion might cause excessive distress, such agreement may not be appropriate. The acting deputy governor informed the review panel that all senior officers are being trained as first responders in the near future.
51. As mentioned earlier in the report, we have made recommendations about resuscitation at Albany in the past, although these have been with regard to terminally ill prisoners. Many of those present at the clinical review panel have been involved in those cases and are aware of the issues that have arisen. While the decision not to attempt CPR for the man was appropriate, the review panel agreed two recommendations about resuscitation. While we endorse these, we make a recommendation of our own to ensure that this issue is fully discussed at Albany:

The Governor and Head of Healthcare should ensure that all staff are clear about their expectations about attempting resuscitation

52. The review panel found that the provision of healthcare for the man was of an equivalent standard to that he might have received in the community.

Use of the sanitation system

53. The issues surrounding the electronic sanitation system used on A wing were discussed by the review panel. The man was formally warned for exceeding the permitted time of seven minutes allowed out of his cell on day sanitation. On A wing there are no toilets in the cells and prisoners have use of either a lidded bucket or access to electronic day/night sanitation (this is when the cell door unlocks for a limited time to allow the prisoner to go to the toilet).
54. The man was 88 years old, had poor mobility and used a walking stick. The iron correctly prescribed to treat him caused him to suffer from diarrhoea for several weeks.
55. When the man was seen by a nurse on the day he died, he had told her he was still troubled by his upset bowels and problems accessing the toilet. The nurse spoke to the doctor who agreed that he needed 24 hour access to a toilet and he added the man to the waiting list for F or G wing, where cells have a toilet in the cell.
56. The acting deputy governor confirmed to the review panel that the usual process was that prisoners are allowed five seven minute visits to the toilet per night. This used to be nine minutes. The healthcare manager confirmed that healthcare is looking into providing 'porta potties' for A wing and that they have been piloted for the previous six weeks.

57. Having to use buckets in cells is unacceptable and degrading, as are the automatic sanitation arrangements. Albany houses a population in which the average age is high compared to most prisons, making those who are either elderly, disabled or less mobile more susceptible or more likely to require easier access to toilet facilities.
58. We have previously made a recommendation about this issue, in a report received by Albany two months before the man died. We do not expect Albany to have resolved this issue before the man died. However, we note that in their response to that recommendation, they agreed that elderly prisoners who had difficulty using the sanitation system should not be on that wing, and that they would revise their local policy accordingly. In order to ensure that this is done, we repeat the recommendation:

The Governor should ensure that if a prisoner is unable to easily use the night sanitation system they should not remain on that wing.

59. We are also concerned a person in this man's circumstances was given a formal warning for not being able to return to his cell in time. Given his mobility issues and reaction to medication, this seems to have been a disproportionate response.
60. That the sanitation system at Albany is unsuitable in a modern prison system is not in doubt, and the IMB and Chief Inspector of Prisons have also made their concerns clear. The man's case is a powerful example of the impact it can have on an individual. We will be sending a copy of this report to the Secretary of State for Justice to ensure that he is aware of the urgent nature of this issue.

CONCLUSION

61. The man had pre-existing medical conditions which were stable when he entered prison, and he continued to receive his usual medication. He was seen regularly by the doctors and nurses in prison healthcare. The blood tests taken from him at HMP Bristol were abnormal, but he had transferred prisons before the results came back. The delay whilst these tests were repeated was unfortunate, but was not material to his death.
62. Three months after his imprisonment and two months after arriving at HMP Isle of Wight, the man was found unresponsive on his bed in his cell on a day in September 2011. He was 88 years old. He had collapsed unexpectedly due to longstanding damage to his heart from hypertension. The post mortem confirmed that the man's cause of death was from hypertensive and ischaemic heart disease.
63. The clinical reviewer confirmed that the man's care was equivalent to that he would have received in the community. We concur with this view.
64. However, this investigation has once more raised concerns about the sanitation system currently used on many of the wings at Albany. While the appropriateness of the system itself is open to question, it is undoubtedly the case that it is unacceptable for an 88 year old man with illness and mobility issues to be housed in such circumstances.

RECOMMENDATIONS

1. The Heads of Healthcare at Bristol and the Isle of Wight should ensure that, when abnormal results are received after a prisoner leaves a particular site, every attempt is made to highlight those results and forward them to their new site, or GP, if they have left custody.

NOMS accepted the recommendation and commented: Although this is a rare event, upon receipt of a clinically significant test result for any prisoner who has left the establishment, every effort is made to bring this to the attention of the patient's current clinician/s. Where the individual has been transferred to another prison, the information is scanned onto SystmOne and the receiving prison advised. Where the individual has been released, if their GP is known to Prison Healthcare, or can be identified via the Offender Management Unit. Instructions have been given to Prison Healthcare administrative staff to this effect.

2. The Head of Healthcare should ensure that where new prisoners have significant medical histories, or are prescribed regular medication, second reception health screens should be by a GP.

NOMS accepted the recommendation and commented: "On reception the nurse will check if the patient is on medication. Prisoners with significant medical history and/or taking medication will be appointed to see the GP ASAP. This may be initiated by the initial health screening or via the second reception screen which allows nursing staff to triage appropriately based on the information from the assessment. Prisoners transferred from other prisons arrive with medication in most cases. If the sending prison fails to send medication, Prison Healthcare staff will arrange for a GP to re write the prescription and send to Pharmacy and if necessary use the emergency cupboard stock to issue for the first evening/night. Prisoners arriving late in the day without medication will be assessed and where appropriate the prescription will be completed the following morning. Any medication required urgently/before the following day is dealt with at the time via the GP Out of Hours Service and the on call Pharmacist at the local hospital. The proposed single Reception into HMP Isle of Wight will be of considerable assistance in streamlining and improving the efficiency and effectiveness of the healthcare elements of the Reception process."

3. The Governor and Head of Healthcare should ensure that all staff are clear about their expectations about attempting resuscitation

NOMS accepted the recommendation and commented: It has been agreed that the default position for Prison and Healthcare staff should be that resuscitation would be attempted unless there is a clear Do Not Attempt Resuscitation (DNAR) plan in place. The patient should be actively involved in the discussions around decisions not to resuscitate wherever possible. The DNAR decision pathway should be in evidence in the records and clear to all should an emergency situation arise. A total of 12 Automated External Defibrillators are now in place across HMP Isle of Wight. Four are sited in

clinical areas, the remainder are dispersed across general areas that include gymnasiums, night orderly offices and two wings that accommodate more frail and elderly prisoners

4. The Governor should ensure that if a prisoner is unable to easily use the night sanitation system they should not remain on that wing.

NOMS accepted the recommendation and commented: "In general, prisoners who find it difficult to use the night sanitation system are moved to F&G wings in Albany site. Prisoner is also offered the opportunity to move to Parkhurst site, if they are not able to be located in F&G wings. This will now formally form part of the local policy."