

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at hospital in
July 2012, while a prisoner at HMP & YOI Bristol**

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. He was 59 years old and died in hospital in July 2012, while he was a prisoner at HMP Bristol. The preliminary cause of death was found to be sepsis (a fatal reaction to an infection). I offer my condolences to his family and friends.

The local Primary Care Trust appointed a clinical reviewer to conduct a review of the clinical care the man received while in custody. Staff at Bristol cooperated with this investigation.

The man was very unwell before he arrived at Bristol and suffered from a number of conditions which reduced his mobility. He had a history of heart disease and was being treated for acute kidney failure, but died unexpectedly of an infection. The clinical reviewer does not consider that all aspects of his medical care at Bristol were equivalent to that he could have expected in the community, but there is no evidence that any of these contributed to his death.

Although the man was a low risk prisoner he was subject to restraints on two occasions when he went to hospital which was not justified by a properly considered risk assessment. I am also concerned that his family were not informed early enough of his admission to hospital with a serious illness, so were not able to see him before he died and that the prison's contribution towards the funeral costs was less than I would have expected.

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

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SUMMARY

1. The man received a ten week sentence on 29 June 2012. He collapsed at court and was admitted to hospital. He was discharged from hospital the following day and was taken directly to HMP Bristol and admitted to the inpatient unit in the healthcare centre.
2. The man had a number of long term conditions including high blood pressure, ischaemic heart disease (reduced blood supply to the heart muscle), sleep apnoea (abnormal breathing during sleep) and anxiety.
3. He was admitted to hospital on two further occasions before his final admission on 24 July. On the second admission, the hospital concluded that his symptoms were caused by anxiety, and on his third visit to the hospital on 12 July, a pulmonary embolus (blocked lung artery) was diagnosed.
4. The man returned to prison on 16 July and was moved from the healthcare centre to one of the wings. Following this, he began to complain about a variety of pains, including chest pains, pains in his back and a painful knee. The pain in his knee increased to the point that he was unable to stand on it.
5. On 24 July, the prison received a telephone call from the hospital stating that the man's blood results showed his creatinine levels were dangerously high and that urgent admission to hospital was required. (Creatinine is a breakdown product which is processed by the kidneys, so high levels of it indicate that the kidneys are not working properly.) He was admitted to hospital that day and on 25 July moved to the Southmead Dialysis Unit with possible renal impairment. His condition deteriorated rapidly and he died a few days later.
6. The man's daughter, his recorded next of kin, was informed about his hospital admission on 25 July. His family was informed when his death occurred, and a prison family liaison officer went to the hospital to meet them.
7. This report makes recommendations concerning medical record keeping, improving the reception process for prisoners arriving from hospital, the management of patients on warfarin, improving risk assessment procedures for restraints, notifying families when a prisoner is taken to hospital and the payment of funeral costs.

THE INVESTIGATION PROCESS

8. The Ombudsman's office was informed of the man's death on 26 July 2012. The investigator issued notices to staff and prisoners informing them of the investigation and inviting anyone with any relevant information to contact her. No one came forward.
9. The investigator visited HMP Bristol on 2 August and spoke to the healthcare manager and the two prison family liaison officers. She also met a representative from the Independent Monitoring Board.
10. The local Primary Care Trust (PCT) asked a clinical reviewer to carry out a review of the clinical care the man received while at Bristol. His report was received on 4 November 2012.
11. The investigator returned to Bristol on 20 September 2012 and interviewed seven members of staff.
12. HM Coroner for Avon provided the results of the post-mortem examination and will be sent a copy of this investigation report.
13. The man had two daughters, one of whom was his nominated next of kin. One of the Ombudsman's family liaison officers contacted that daughter to explain the purpose of the investigation and provided the opportunity for his family to identify any issues for the investigation to consider. She had the following concerns:
 - Her father had been afraid that he would die in prison and his family believe that he was left on his own for lengthy periods with chest pains.
 - His family found it difficult to find out how he was and when he had been admitted to hospital, and had experienced difficulties scheduling visits. His daughter and his wife did not have the opportunity to see him during his final admission and felt they were informed of developments too late.
 - The family believe they were not offered the full amount available towards funeral costs.
14. The man's daughter also mentioned problems getting his personal letters returned. We understand the prison erroneously considered the Coroner might require them, but this issue has now been resolved.
15. The man's family received a copy of the draft report. They raised a number of questions which led to no significant changes to the investigation report. However, we have sought to clarify and provide further information (by separate correspondence) where appropriate to the points raised by the family. We continue to pursue the matter of funeral expenses with the prison service.

HMP BRISTOL

16. HMP Bristol is a local prison holding just over 600 convicted and remanded adult male prisoners, and a limited number of young adults from local courts.
17. In July 2012, the inpatient facility at HMP Bristol was a 20 bed unit managed by Avon and Wiltshire Partnerships Trust (AWP). AWP staff provided cover from 7.00 in the morning until 11.30 at night alongside physical health nursing input from Bristol Community Health (BCH). BCH staff also provided cover from 11.30 at night until 7.00 in the morning. (The unit is now a residential unit with intensive support interventions provided by mental and physical healthcare providers.)
18. The man spent most of his time at Bristol in the healthcare centre, when not in hospital, and only briefly spent time on the wing.

HM Inspectorate of Prisons (HMIP)

19. HMIP last inspected Bristol in January 2010. The report summarised the inspection finding about healthcare as follows:

“Prisoners’ perceptions of the quality of service provided by the doctors and dentist were poorer than those at other local prisons. The healthcare centre was well managed and provided a good level of service. Relationships with the commissioning Trust were good. Primary care, inpatient and mental health services were provided by a team of well qualified staff with a good skill mix. Treatment rooms were available on each of the wings. The healthcare facilities in reception were good, with satisfactory primary and secondary screening. There were a range of nurse-led and specialist clinics. Dental services were adequate but there were long waiting lists and concerns about infection control. The inpatient beds were on the certified normal accommodation. The atmosphere on the unit was relaxed but the regime limited. External hospital appointments were well organised and timely.”

Independent Monitoring Board (IMB)

20. 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 IMB report for the year until 31 July 2012 says of healthcare:

“Staffing has remained stable and at acceptable levels throughout the year, although when inpatient levels are close to maximum capacity, pressure on staff is noticeable. There are currently five GPs, of whom two are full time. A new Primary Care Manager (appointed in early 2012), who is substance misuse trained, has replaced the Healthcare Manager.”

Prisoner Security Classification

21. All adult male prisoners are classified on reception into prison and put into one of four security categories based on the likelihood of escape and the risk to the public if they did escape. The categories are: Category A prisoners who would be highly dangerous to the public, police or national security if they were to escape; Category B prisoners for whom the highest security conditions are not necessary, but for whom escape needs to be made very difficult; Category C prisoners who cannot be trusted in open conditions but who are unlikely to make a determined escape attempt; and Category D open conditions, prisoners who can be trusted not to try and escape.

Previous deaths at HMP Bristol

22. There have been two deaths through natural causes in the last three years at Bristol. In the most recent investigation the Ombudsman recommended appropriate monitoring of renal function where drugs have been prescribed to deal with high blood pressure and that every prisoner returning to Bristol after a hospital admission is assessed by a healthcare professional in reception. We have found similar issues in this investigation.

KEY EVENTS

23. On 29 June 2012, the man was sentenced to ten weeks imprisonment. At court he experienced chest pains and was taken to hospital. He stayed in hospital overnight and was discharged the next day to HMP Bristol. It is unclear what happened when he initially arrived at the prison, as there is no record for 30 June. The records show that he was based in the inpatient unit in the healthcare centre on 1 July, and had apparently arrived there at 7.30pm the evening before. It does not appear that standard reception procedures had taken place when he arrived as a entry in his medical record of 1 July indicates that he was not registered on the healthcare system, or the P-NOMIS electronic prison record, that no cell sharing risk assessment had been completed and that there was no discharge summary from the hospital. (This was attached to his records after his death and showed a diagnosis of anxiety.) Records show that prison healthcare staff tried to get information from the hospital by telephone about his treatment there but were unable to get a reply.
24. At approximately 2.20pm on 1 July, a practice nurse, assisted by two other nurses, assessed the man's health. He said that he was experiencing radiating chest pains, and they decided that he needed to go to hospital for a further assessment. According to an escort risk assessment he went to hospital at 4.00pm on 1 July. The risk assessment shows that he was considered a category B prisoner, but that he was regarded as low risk. The risk assessment indicated that double cuffs and an escort chain should be used. (The security governor later explained that this meant that double handcuffing was used for the journey and an escort chain was used for treatment in hospital.)
25. The man was discharged from hospital on 3 July, with a diagnosis of anxiety. The hospital discharge records show that his prescription of ramipril (a drug which treats high blood pressure and certain heart conditions) had been increased and that his urea and electrolyte levels (U&E - measure of kidney function) should be monitored along with his blood pressure and pulse rates. There is no record that these tests were carried out when he returned to the prison.
26. It was decided that the man should remain living in the prison's inpatient unit in the healthcare centre for a GP and Community Mental Health Team assessment. A prison doctor saw him the same day and noted that he was currently taking diazepam (an anxiety relieving drug) he decided to monitor his need for this before prescribing it further.
27. The man was formally categorised as a category D prisoner on 3 July, the lowest security category. He attended a court hearing on 5 July, and collapsed once more at the court. Although he was categorised as D, the risk assessment recorded that he was considered a category B prisoner and double handcuffs were used.

28. On 6 July, following a management check on the bedwatch (when a prisoner stays in hospital the escort arrangements are known as a bedwatch), a further risk assessment was carried out. This indicated that the man was a category D prisoner and the escort was reduced to one officer, but he was still restrained by an escort chain. The reason for this was not explained.
29. It is not clear from the records when the man was discharged from the hospital and returned to the prison, but there is an entry in his healthcare record of 9 July indicating that he was back in the inpatient unit at the prison. Healthcare staff decided that there was no further medical reason why he should remain in the inpatient unit and, although he was anxious about this, he moved to a standard prison wing on 10 July.
30. About 2.15pm on 12 July, the man told a practice nurse that he had a radiating pain in his left side. He said the pain had started several hours before but he had not wanted to cause a fuss. A doctor attended and he was taken to hospital accompanied by one officer and no restraints were used. He stayed in hospital for four days while a number of tests were carried out. He was diagnosed with a pulmonary embolus and started on warfarin and clexane (drugs which prevent blood clots).
31. The man came back to the prison from hospital on 16 July. The records show that he was taken straight to the inpatient unit in the healthcare centre.
32. On 17 July, the man was moved from the healthcare centre to D wing. He complained of chest pains and a severe headache that day. His medical record shows that observations were carried out and that he was able to talk well with no breathlessness. Nothing of concern was found. A practice nurse advised him not to overuse his GTN spray (Glyceryl trinitrate – used to treat angina).
33. On 18 July, the man reported pains in his mid-back and on 20 July a swollen and painful knee. A prison doctor examined him and noted that he was unable to walk or stand and he could only bend the knee a limited amount. Healthcare staff were aware he had had a total knee replacement operation in the past. Later that day a nurse saw him and was concerned about the possible effects of his immobility. She asked another nurse to arrange for him to be reviewed the next day and advised him to sit up as much as possible.
34. A nurse saw the man at 4.42pm and another nurse saw him at 7.11pm on 21 July about his knee pain. He was given ibuprofen (an anti-inflammatory pain killer) and told that a doctor would see him the next day. He said the pain in his knees was getting worse and he was having difficulty walking. On 22 July, a nurse gave him ibuprofen and took him to the inpatient unit overnight for observation. A prison doctor saw him on 23 July and concluded that he was suffering from osteoarthritis possibly exacerbated by his lack of mobility.
35. On 24 July, the man had an INR blood test. INR (International Normalised Ratio) is a measure of blood clotting times. INR levels of patients taking warfarin should be checked regularly to ensure their blood is within therapeutic

levels. His level had risen to eight, which was outside his therapeutic level, and as a result his warfarin was stopped. The record indicated that warfarin would not be prescribed again until his INR was below five.

36. On the same day, the hospital telephoned the prison to say that the man's blood sample showed creatinine levels of over 600, which was an indicator of acute renal failure and that he needed to be admitted to hospital as soon as possible. (The blood sample had been taken at the prison, but there is nothing in his medical record to show when or why. The investigation discovered that a blood sample had been taken when he had mistakenly been sent to the Hepatitis C clinic.) He was taken to hospital by ambulance escorted by one officer. No restraints were used.
37. On 25 July, the man was transferred from the hospital to the renal unit at another hospital, with possible renal impairment. His medical records show that he was expected to stay one week. However, his condition deteriorated rapidly and he later died.

Contact with the man's family

38. The man's wife had been sentenced at the same time as him and was in custody at HMP Eastwood Park. We understand that after he was sentenced he did not speak to his wife by telephone and it does not seem that the possibility of making an inter-prison phone call was explained.
39. The man's daughter, who was listed as his next of kin in his prison record, tried to arrange a visit to see him before his last admission to hospital but the prison visits phone line was not working. On 23 July, she was able to contact the prison and tried to arrange a visit that day. She was told that same day bookings could not be arranged unless the situation was urgent, which her father's situation was not at the time.
40. The next day, 24 July, the man was admitted to hospital. On 25 July, the prison was informed that he had possible renal impairment and his likely length of stay in hospital was one week. Later on 25 July, an operational manager was told by healthcare staff that there was a possibility that his condition could become serious and he telephoned the man's daughter to let her know her father was in hospital.
41. The man's daughter contacted the chaplaincy at Eastwood Park to ask them to let her mother know that her father was unwell. The duty governor at Eastwood Park contacted the operational manager at Bristol, who told her that the man's condition was serious but not life threatening. The man's wife was informed and was told that she would be updated if there was any further news.
42. On the morning the man died, the prison was informed that he was in a critical condition. An operational manager at Bristol contacted the man's daughter and Eastwood Park. The man's daughter said this was at 5.30am and she started to drive to the hospital from Cornwall. He died at 6.32am and the

prison family liaison log records that she was informed while she was driving from Cornwall. His daughter says that it was her sister who told her of their father's death and not the prison.

43. The prison family liaison officer (FLO) went to the hospital with the prison chaplain. They met both of the man's daughters, his wife, who had been brought from Eastwood Park, and other family members. The FLO offered support and said that the prison would contribute towards the funeral costs in line with national Prison Service guidance.

Support for staff and prisoners

44. After a death, prison managers are expected to hold a debrief with the staff involved to provide support. Bedwatch officers were invited to a debrief but did not attend.
45. The man was in prison for only a very short time. He spent most of his time in the healthcare centre and had not made any close acquaintances. However prisoners were informed of his death through a Governor's notice and support was offered if required.

Post-mortem

46. A full post-mortem report was not available at the time of writing this report, but a cause of death was provided by the Coroner as:
 - 1a sepsis
 - 1b bronchopneumonia
 - 1c immobility due to pulmonary embolus
- 2 Acute kidney failure and Ischaemic Heart Disease.

ISSUES

Clinical Care

47. The man had a number of long term conditions including high blood pressure and ischaemic heart disease. Although he was at the prison for only a very short time the clinical reviewer notes that there was no evidence that there were any plans to manage his chronic conditions systematically and that care appeared to have been given on a reactive basis. He has made a recommendation about this which the Head of Healthcare will wish to consider.
48. Clinical record keeping was poor. Important elements of the man's clinical picture were not entered on the medical record (SystemOne – the healthcare computer system). The fact that he had a history of heart problems, sleep apnoea and impaired fasting glycaemia (a pre-diabetic condition) were not included in his record. It is important that medical records are kept fully up to date, and key information regarding previous medical conditions and hospital admissions is entered to ensure continuity of care.

The Head of Healthcare should ensure that medical records are updated on SystemOne, particularly when summary records from primary care become available to include any key diagnoses, follow up and treatment.

49. This investigation indicated there was a lack of a structured process for receiving prisoners from hospital and then transferring them to the inpatient unit in the healthcare centre. The man's medical record shows that he was twice located in the inpatient unit without any record of a handover or information about his condition. Bristol Community Health's review shows that this happened a third time when he was discharged from hospital. Healthcare staff said that this was not unusual.

The Governor and the Head of Healthcare should ensure that the reception process for prisoners arriving from hospital includes a full reception health screen by a qualified nurse, that information is entered appropriately on prison and healthcare records and that there is a verbal handover to healthcare staff.

Kidney function

50. On his return to prison from hospital on 3 July, the discharge summary recommended that the man's urea and electrolyte levels (U&E - measure of kidney function) should be monitored along with his blood pressure and pulse rates. The clinical reviewer confirms that the U&E tests were due to be carried out ten days after discharge, by which time he was back in hospital. We note that his acute kidney problems were discovered only as a result of a blood test taken at his apparently unscheduled attendance at the prison's Hepatitis C clinic.

51. On 20 July, the man reported pains in his back. We asked the clinical reviewer if this could have been a symptom of kidney problems, he said that acute renal failure is difficult to diagnose. Until quite a late stage it can present with very few symptoms. He believes that his multiple presentations to healthcare might have been related to his kidney problems but this is something which it is difficult to be certain about.

Management of the man's chest pain and blood tests

52. The man complained of chest pain a number of times. The records show that on several occasions he was taken to hospital for further assessment. The hospital twice discharged him with a diagnosis of anxiety. On the third occasion a diagnosis of pulmonary embolism was made and he was prescribed warfarin and clexane to manage this.
53. The clinical reviewer says that the monitoring of the man's reaction to warfarin should have been tighter, especially as this was newly prescribed. Warfarin thins the blood and it is important to measure the clotting levels of the blood with an INR test. At one point, there was an interval of five days between tests, which he considers was too long. At the time of the second test, his INR level had raised to eight, which was outside his therapeutic level. The clinical reviewer notes that Vitamin K (which reverses the anti-clotting) should be available on the same day for very high INR readings; however he was not given it. He says there is no evidence that this contributed to his subsequent admission to hospital.
54. The clinical reviewer also points out that the man was prescribed two non-steroidal anti-inflammatory drugs (NSAIDs) that were not appropriate to be taken in conjunction with warfarin. Naproxen and Ibuprofen (drugs which treat pain arising from inflammation) were prescribed without the risks being clearly documented or measures taken to prevent bleeding.

The Head of Healthcare should ensure that healthcare staff are fully aware of the appropriate management of warfarin to include monitoring regimes, co-prescribing of anti-inflammatory drugs and managing and treating abnormal INRs.

Use of restraints

55. The Prison Service has a duty to protect the public when escorting prisoners to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in 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.
56. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same

prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process.

57. It is hard to see how the risk assessments reached the conclusion that restraints were necessary for a man in the man's state of health and who was a category D prisoner. Even when he was not yet categorised or mistakenly believed to be category B, an individual risk assessment should have noted that he was convicted of an offence which carried very little risk and his health meant he was no risk of escape. There was no healthcare assessment of his risk.
58. Double cuffing entails the prisoner having his hands cuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs. This is usually required for moving category A or category B prisoners in good health. When, exceptionally, double cuffs are used for a category C prisoner the Prison Service requires that reasons should be recorded in writing. The guidance does not envisage circumstances when double cuffs would be used for a category D prisoner. There is no evidence to support the decision to use double cuffs and we can see no reason how it could have been justified. We note however that during the man's final admission he was escorted with just one officer and no restraints were used.

The Governor should ensure that escort risk assessments accurately reflect the prisoner's actual risk at the time and take account of a prisoner's medical condition.

Contact with the man's family

59. When the man's daughter requested a visit on 23 July, this was not allowed as the prison's practice is that same day visits are only considered in urgent circumstances. At the time he was not considered seriously ill. As he was unwell and his daughter had previously been unable to contact the prison through the visits booking line, we think it is unfortunate that the prison did not exercise appropriate discretion to allow the visit. It is regrettable that neither his wife nor his daughters were able to visit him before he died. Although we accept that the prison could not have foreseen how rapidly his condition would deteriorate, Prison Rule 22 says that "if a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of a 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".
60. We believe that the man's urgent admission to hospital was an indicator that he was seriously ill and in accordance with Prison Rule 22 his wife and daughter should have been informed of his urgent admission to hospital on 24 July. There were no security reasons which would have precluded this and earlier notification might have allowed them the opportunity to visit him before his death.

The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible after they are admitted to hospital.

61. There was some confusion over exactly how much the prison was prepared to pay towards the man's funeral. Prison Service Instructions (PSI 64/2011) state that the prison must offer to pay a contribution towards reasonable funeral expenses of up to £3,000. Reasonable costs may include funeral director's fees, the hearse, a simple coffin, cremation or burial fees (but not the cost of a burial plot) and Ministers' fees. Costs should not include any headstone, embalming, use of the chapel of rest, and flowers. The total cost of the funeral was £3,300. The prison paid for just the disbursements which were £1,054. Disbursements usually cover only Ministers fees, crematorium or burial costs and the costs of a church service rather than the funeral director's fees. We are not satisfied that the prison made a reasonable contribution to the cost of the funeral in line with Prison Service guidance.

The Governor should ensure that, in line with Prison Service guidance, an appropriate contribution is made to the man's family to cover the reasonable costs of his funeral.

CONCLUSION

62. The man was in poor health with a number of serious conditions when he was sentenced to prison. The clinical reviewer concludes that not all aspects of the care he received in prison were equivalent to that he could have expected in the community. Some involved poor systems, but there is no evidence that these deficiencies would have prevented his death.
63. On two occasions when the man attended hospital restraints were used when they were not justified by security concerns. We are also concerned that the prison did not inform his family of his admission to hospital early enough which would have allowed them the opportunity to see him before he died.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that medical records are updated on SystemOne, particularly when summary records from primary care become available to include any key diagnoses, follow up and treatment.

Accepted: SystemOne training is now mandatory for all staff. Communications between disciplines/departments and agencies is much improved and is subject to regular audits.

2. The Governor and the Head of Healthcare should ensure that the reception process for prisoners arriving from hospital includes a full reception health screen by a qualified nurse, that information is entered appropriately on prison and healthcare records and that there is a verbal handover to healthcare staff.

Accepted: A NTS 156/2012 was issued to all staff; this reiterated the importance of prisoners having to go through reception and being screened by a qualified nurse. NTS 174/2012 states that all new receptions are now located on D wing, all detoxing prisoners go to C wing and complex cases (medical beds) go to Brunel wing.

It is now standard practice that all prisoners are seen by a qualified nurse in reception. Reception screening is now subject to audit.

3. The Head of Healthcare should ensure that healthcare staff are fully aware of the appropriate management of warfarin to include monitoring regimes, co-prescribing of anti-inflammatory drugs and managing and treating abnormal INRs.

Accepted: There is an expectation that all qualified nurses that are 'general' trained would have a working knowledge re the use of warfarin and INR ranges. Refresher training to be delivered to the nursing team in a workshop format.

4. The Governor should ensure that escort risk assessments accurately reflect the prisoner's actual risk at the time and take account of a prisoner's medical condition.

Accepted: The Governor accepts that escort risk assessments should accurately reflect the prisoner's actual risk at the time and take account of a prisoner's medical condition.

5. The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible after they are admitted to hospital.

Accepted: The man's family were informed of his condition on the day following admission by the Duty Governor. When the escorting staff were aware of the deterioration in his condition the Night Orderly Officer made contact with one of his daughters and the EWP. In future The Head of Healthcare will need to fully brief the duty Governor about the condition of

prisoners who are escorted via ambulance, so that next of kin can be informed.

6. The Governor should ensure that, in line with Prison Service guidance, an appropriate contribution is made to the man's family to cover the reasonable costs of his funeral.

Not accepted: The FLO met with the family at their home and assurances were made to the FLO that they had funds for the funeral and only requested £1054 to be contributed towards the disbursements. This was because the money was needed up front. The FLO agreed to make this contribution and the family were delighted that the funeral would be going ahead as planned.

The contribution was in line with PSI 64/2011 which states 'Prisons must offer to pay a contribution towards reasonable funeral expenses of up to £3,000.'