PRISONS AND PROBATION
OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a woman at hospital in March 2013, while a prisoner at HMP New Hall

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 investigation report into the death of a woman who died in March at hospital while a prisoner at HMP New Hall. The provisional cause of her death was septicaemia (blood poisoning). She was 31 years old. I offer my condolences to her family and friends.

A clinical reviewer reviewed the care the woman received at New Hall. The prison cooperated fully with the investigation.

The woman became suddenly very unwell in March and died in hospital five days later. In the days before her death she had back ache, but she did not seek medical treatment for this. Otherwise, we have found no indications that her health was deteriorating. Officers and prison nurses responded appropriately and quickly when it became clear that she was unwell.

Records show that between September 2012 and February 2013, the woman requested pain relief medication almost every day, apparently suffering with toothache and headaches. However, she missed a number of booked appointments with the dentist and doctor, and for routine tests and so the cause of the pain was never established. The clinical reviewer is concerned about the quality of medical record keeping at New Hall and about how prisoners who miss numerous healthcare appointments are encouraged to attend, and I agree that while it would have been difficult for the prison to predict or prevent her death, more could have been done to help her look after her health.

I am also concerned that the woman's family was not informed more quickly that she was in hospital, although it was clear that she was seriously unwell. Restraints were used when she was taken to hospital which I am not satisfied was properly justified by a fully informed risk assessment.

This version of my report, published on my website, has been amended to remove the names of the woman who died and those of staff and prisoners involved in my investigation.

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

CONTENTS

Summary

The investigation process

HMP New Hall

Key events

Issues

Recommendations

SUMMARY

1. The woman was remanded to New Hall in July 2012. It was not her first time at the prison. She had a history of substance misuse and immediately began an alcohol detoxification programme and was prescribed Subutex (a heroin replacement medication). No other immediate health concerns were identified.

2. Between September 2012 and February 2013, records show that the woman sought and was given pain relief medication almost every day, apparently because of toothache and headaches. She was also prescribed two courses of antibiotics. She consistently failed to attend healthcare appointments with the doctor and the dentist so the cause of the pain was never established. Entries in her medical record are extremely brief and provide little information about the nature of the pain, why she missed her booked appointments or why medication was prescribed to her. She was last given paracetamol at the prison on 2 February 2013.

3. The woman saw a nurse every day to receive Subutex, but did not mention any health problems in the days before 9 March and did not seek any medical help, although on 7 March, she wrote in her diary that she had back ache. She did not mention this when she saw the nurse on the morning of 8 March but asked an officer to collect her tea that afternoon because her back hurt. She declined the officer's offer to have a nurse examine her.

4. At about 10.00am on 9 March, the woman pressed her cell bell. The officer who responded realised that she was not well and asked a nurse who was dispensing medication on the wing to assess her in her cell. The nurse came immediately and, after taking some basic observations, asked for an emergency ambulance to be called. The nurse continued to examine her, but found it difficult to locate a pulse or take her blood pressure reading. Paramedics arrived at 10.15am and established that her blood pressure was very low. They took her to hospital and later that day, she was admitted to the Intensive Care Unit. A few days later, she suffered a cardiac arrest and was resuscitated. Two hours later, she had a second cardiac arrest but could not be resuscitated and died at 1.45pm. The provisional cause of her death was given as septicaemia.

5. We have found no evidence of any earlier indications that the woman's health was deteriorating before she became ill on 9 March. It seems she did not raise any specific concerns about her health except to complain of back ache the day before. Officers and prison nurses responded with appropriate urgency and efficiency when they found her unwell on the morning of 9 March.

6. The woman's medical record contains limited information about her health while she was at New Hall and we are concerned about the standard of healthcare record keeping. More should be done (and subsequently recorded in the medical record) to establish why a prisoner misses healthcare appointments and to support and encourage them to attend. We have also made recommendations to ensure that a prisoner's family is contacted when a prisoner is seriously ill and about the use of restraints for seriously unwell prisoners.

THE INVESTIGATION PROCESS

7. The Ombudsman's office was notified of the woman's death on 14 March 2013. The investigator issued notices to staff and prisoners at HMP New Hall to inform them of the investigation and asking anyone with relevant information to contact her. No responses were received.

8. The investigator visited New Hall on 21 March and met the Governor, Head of Healthcare, the prison family liaison officer and a representative of the POA (the prison officers' union). She obtained copies of the woman's prison and prison medical records and other relevant documentation.

9. The local PCT commissioned a clinical reviewer to undertake a review of the clinical care the woman received at New Hall. Interviews with staff were carried out by telephone in July 2013. After the interviews, the Governor was given written feedback.

10. HM Coroner for West Yorkshire Eastern District was informed of the investigation. The result of the post-mortem was not available before the draft report was issued but a provisional cause of death from septicaemia was given. This report has been sent to the Coroner.

11. One of the Ombudsman's family liaison officers contacted the woman's mother to explain the purpose of the investigation and invite her to identify any relevant matters she wished the investigation to consider. She did not raise any specific questions about her daughter's death.

12. The woman's mother received a copy of the draft report and did not wish to make any comments or raise any inaccuracies or omissions.

13. The Service also received a copy of the draft report and did not raise any inaccuracies. Their response to the recommendations is included.

HMP NEW HALL

14. HMP & YOI New Hall is a closed prison which holds up to 446 adult and young adult women with a small unit for girls under 18, the Rivendell Unit. There are three main residential units, Oak, Willow and Poplar. Most of the accommodation is in single cells.

15. Primary healthcare is commissioned by the NHS and provided by a private company. Healthcare staff are available 24 hours a day.

Her Majesty's Inspectorate of Prisons

16. HM Inspectorate of Prisons (HMIP) last inspected New Hall in February 2012. The Inspectorate noted that health services were not fully integrated into the prison meetings structure which led to misunderstandings. HMIP also considered that there should be a health promotion strategy and a systematic health promotion campaign through the prison. However, they reported that there was a good range of clinics and women had prompt access to a doctor, although many women said they were not told when appointments were made. A reasonable pharmacy service was provided, but more attention to the management of medicines on the wings was needed.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In their latest published annual report, the IMB was positive about the standard of healthcare provided by the private company.

Previous deaths at New Hall

18. The woman is the fourth woman to die at New Hall since 2010. There are no similarities between the circumstances of the deaths or the recommendations made.

KEY EVENTS

19. On 23 July 2012, the woman was remanded into custody at New Hall, charged with conspiring to pervert the course of justice. She had been in prison several times before, serving sentences as both a young offender and an adult prisoner.

20. The woman's health was assessed when she arrived at New Hall. She said she had a history of heroin use and was being prescribed 16 milligrams (mg) of Subutex (a heroin replacement medication) by her local community drugs team, but also smoked heroin twice a week. She said that she used 150mg of benzodiazepines (a sedative medication which is often misused) every day and used £10 worth of cocaine a week. She said that she had injected drugs in the past. She said that she drank alcohol excessively and she began an alcohol detoxification programme which she completed on 1 August. She was prescribed Subutex and healthcare staff noted that she might also need a benzodiazepine detoxification in due course. She was given a cell on Oak unit, the detoxification and maintenance unit for women withdrawing from alcohol or drugs or receiving heroin replacement treatment under clinical supervision.

21. On 31 July, the woman decided that she did not want support from the Counselling, Assessment, Referral, Advice and Throughcare Service (CARATS – which provides interventions and services for prisoners with drug and alcohol problems). She said that she was stable on Subutex and only had a minor problem with alcohol misuse and had applied for the prison alcohol awareness course. In early August, a CARATS worker spoke to her again and she reiterated that she did not want further support.

22. On 1 August, the woman was assessed by the prison healthcare well being team and agreed to have a full screen for sexually transmitted infections and a cervical smear test. A smear test was booked for 17 August, but she did not attend the appointment. She also failed to attend an appointment with the dentist on 16 August. She missed another planned smear test on 11 September.

23. On 25 September, the woman told a nurse she was suffering from toothache and was given a dose of paracetamol. Two days later, she did not attend a booked appointment with the dentist. Between 27 September and 28 October, she was seen by a nurse almost daily, complaining of toothache. She was given a dose of paracetamol on each occasion. Although the nurses dispensing paracetamol made entries in her medical record, they recorded no further information about the nature of the pain or whether they had carried out any oral examination to help identify the cause of the pain.

24. On 26 October, the woman saw a nurse about the toothache and the nurse made another dental appointment for her. On 29 October, she failed to attend another booked smear test and, when offered an alternative appointment later in the day, refused to have the test. As a result of her missing appointments, she was referred to the well being team.

25. The Head of Healthcare said that prisoners who missed several booked healthcare appointments were referred to the well being team to discuss why

they were failing to attend appointments. She said that the referral served as an opportunity to emphasise the importance of attending appointments.

26. On 1 November, a nurse from the wellbeing team saw the woman. She said that she would like smoking cessation advice and the nurse noted that she was already on the waiting list. She asked to be tested for Hepatitis C and requested another smear test. She said that she had missed her last booked test because it clashed with another appointment. The nurse made no mention of the missed dental appointments or her almost daily requests for pain relief medication.

27. In early November, the woman continued to complain of toothache and received almost daily doses of paracetamol. On 6 November, she had an appointment with a locum doctor, who prescribed a seven day course of antibiotics. The doctor recorded no information about why antibiotics were being prescribed or what kind of examination had been performed. She continued to request paracetamol almost every day throughout November.

28. On 2 December, the pharmacist prescribed a second seven day course of antibiotics, apparently without the woman being examined by a doctor. She failed to attend a booked appointment with the doctor on 5 December. She missed appointments on 6 and 11 December (one of which was for a smear test) but attended an appointment for a Hepatitis B vaccine on 18 December and a smoking cessation appointment on 19 December. She sought and was given pain relief medication because of toothache or a headache almost every day in December. On 5 December, she received an 18 month prison sentence.

29. The woman's pattern of requesting pain relief medication for toothache but missing scheduled healthcare appointments continued in January 2013. On 22 January, the nurse dispensing Subutex recorded that she had checked her mouth to ensure that she had swallowed the medication. She recorded no concerns about any other aspect of the health of her mouth or teeth. The nurse told the investigator that the nurses dispensing Subutex checked the prisoner's mouth before giving them the crushed tablet and again after the medication had dissolved and the prisoner had eaten a biscuit and drunk a glass of water. She said that the primary purpose of the mouth checks was to prevent prisoners from diverting medication for illicit use by other prisoners. She said that during the mouth checks, nurses would normally pick up any obvious dental or oral health problems, although she said it was quite common for prisoners with a history of substance misuse to have poor teeth.

30. The nurse said that prisoners prescribed Subutex spent several minutes with the nurse, waiting for the medication to fully dissolve. She said that during this time, the nurses usually asked about the woman's general health and well being and tended to develop quite good relationships with them. She said she dispensed Subutex to the woman quite often and that she never raised any concerns about her health.

31. The woman was last dispensed pain relief medication on 2 February. There is no information about whether her tooth problem had resolved itself. On 25 February, she attended for a Hepatitis B vaccination. According to her

medical record, she had no other contact of note with healthcare staff (other than to collect her daily Subutex) during February or early March.

7 – 9 March 2013

32. The woman wrote in her diary on Thursday 7 March, that her back was "killing her" and wondered what she had done to cause the pain.

33. At 9.02am on Friday 8 March, the nurse dispensed Subutex to the woman. She told the investigator that there was nothing unusual about her encounter with her that day and that there were no signs that she was unwell. She did not mention her back pain to the nurse. The nurse said that general medication was dispensed in the morning, at lunch time and in the late afternoon. If a prisoner wanted pain relief medication, they could see the nurse at one of these times. Alternatively, they could ask an officer to telephone or radio for a nurse to come and assess the prisoner at any time of day or night. There is no record of her seeking medical help on 8 March.

34. Officer A was working on Oak unit on 8 March. She told the investigator that she unlocked the woman at about 4.15pm so that she could collect her tea. She told the officer that she had back ache and asked the officer to collect her tea for her. The officer offered to contact healthcare staff for her, but she declined the offer saying that the nurses were "crap". The officer collected the woman's tea and delivered it to her cell. She told the investigator that she did not appear to be overly concerned or distressed about her back pain. She said that the woman thought she might have hurt her back at the gym.

35. On the morning of Saturday 9 March, Officer B was one of the officers on Oak unit responsible for unlocking prisoners for morning medication. He told the investigator that he had just unlocked two prisoners on the first floor landing when the woman rang her cell bell, at about 10.00am. When he responded, she was sitting on her bed and asked for her Subutex dose. He told the investigator that she did not seem herself and was very quiet and struggling to speak. He said that she looked a bit pale. While he was talking to her, she "keeled over" until she was lying on her bed. He alerted the officer supervising medication and asked for the nurse in the treatment room to come and assess her.

36. A nurse was dispensing medication with a healthcare support worker when she was asked to assess the woman in her cell. She told the investigator that she was sitting in a slumped position on her bed, with her back against the cell wall. Her immediate observations were that she was pale and clammy and her fingertips were blue.

37. The nurse said that Officer B and the other officer on duty helped to move the woman onto the bed so she could examine her. The nurse said that within a matter of minutes, she decided that an emergency ambulance was needed and asked the officers to request one. The nurse said that she could not find her carotid[1] or radial pulse and struggled to take a blood pressure reading. She explained that these signs indicated that she was quite unwell. Eventually, she found a weak pulse in her foot. She took her temperature,

[1] The carotid arteries take oxygenated blood from the heart to the brain. The pulse from the carotids may be felt on either side of the front of the neck.

which was 40.5 degrees (such a high temperature is often a sign of infection). While the nurse was with her, she vomited a small amount of blood stained sputum.

38. The nurse told the investigator that she asked the woman if she had taken any drugs or done anything unusual which might help explain her condition. She was able to communicate normally and denied any illicit drug use or anything that might have caused her to become unwell. She told the nurse that she had had back ache for a couple of days and had told a member of staff the day before, but had not sought any treatment for it. She said that she had been able to urinate and open her bowels as normal. Her medical record contains no reference to any complaints of ill health or back ache in March. While waiting for the ambulance to arrive, the nurse noticed a rash appear on her body.

39. The first paramedic arrived at the prison at 10.15am and the ambulance arrived at 10.25am. The paramedics carried out observations and at 10.28am, recorded that the woman's blood pressure was 87/58 mmHg, this was abnormally low and she needed to go to hospital.

40. Before the woman left the prison, a risk assessment was carried out to determine the level of restraints to be applied while she was out of the prison. The decision was taken to restrain her with an escort chain (a length of chain with a handcuff at each end for the prisoner and an officer).

41. The ambulance arrived at the hospital at 11.17am. At 12.40pm, one of the two officers who accompanied the woman to hospital, telephoned the prison and told the SO that she would be moved to the Intensive Care Unit that afternoon and would be staying in hospital overnight. The escort chain remained in place except during X-rays and scans.

42. While the woman was in hospital, two officers stayed with her and kept a written log of events. At 8.10am on 10 March, the officers informed the prison that she was not able to move her legs and was weak, but was still able to communicate with them. At 9.05am, the duty governor reviewed the security risk assessment and told the officers to remove the escort chain.

43. The woman remained seriously ill in the Intensive Care Unit for the next few days and was placed on a ventilator. She suffered a cardiac arrest and was successfully resuscitated. She had a second cardiac arrest but could not be resuscitated and it was confirmed that she had died.

Contact with the woman's family

44. At about 7.30pm on 9 March, the hospital suggested that the woman's family be contacted. New Hall had her mother as her listed next of kin. The duty governor established that the hospital had already asked local police to visit her mother and tell her that her daughter was in hospital. The duty governor liaised with the local police and hospital during the evening until the police confirmed that they had spoken to the woman's mother. The woman's family was unable to visit that night but telephoned the hospital for an update.

45. At 10.00am on 10 March, an officer was appointed as the prison family liaison officer. Initially, he planned to meet the woman's parents at the hospital that day, but was unable to coordinate times. Later on 10 March, a chaplain from the prison chaplaincy team met the woman's father at the hospital. The family liaison officer spoke to the woman's mother on the morning of 11 March.

46. After the woman's death, the family liaison officer, an operational manager, a member of the prison's care team and a Roman Catholic chaplain met the woman's family at the hospital. In line with national guidance, the prison offered to contribute to the cost of the funeral. The family was offered the opportunity to visit New Hall and attend a memorial service held in the prison chapel.

Support for prisoners and staff

47. Prisoners on Oak unit were offered support from the prison chaplaincy team and unit officers. All prisoners being monitored as at risk of self-harm or suicide were checked in case the woman's death had affected them. Staff interviewed during the investigation said that they had been well supported by the prison after her death.

Cause of death

48. The post-mortem report was not available before our draft report was issued; however the provisional cause of the woman's death was given as septicaemia (blood poisoning caused by the body overreacting to an infection). Septicaemia can develop from a minor infection anywhere in the body. In approximately one in five cases, the infection which caused the sepsis cannot be detected. We do not know where the infection that led to her septicaemia began.

ISSUES

Clinical care

49. The clinical reviewer considered the woman's medical history at New Hall. From 25 September 2012 until 2 February 2013, she requested and was given pain relief medication almost daily. The limited information in her medical record suggests that this was for toothache and headaches. She missed several appointments with the dentist and it seems that the cause of the pain was never properly established. In November and again in December, she was prescribed a seven day course of antibiotics.

50. The entries in the woman's medical record are extremely brief and without exception contain no detailed information about the nature of her pain, whether any examination had been carried out, what the treatment plan might be or any consideration of the effectiveness or otherwise of the medication being prescribed. This is true of entries by both nurses and doctors. The clinical reviewer comments that "the absence of evidence … makes it difficult to conclude that [her] pain management was and remained appropriate". We make the following recommendation:

    The Head of Healthcare should ensure that that all record keeping is made in compliance with the Nursing and Midwifery Council and General Medical Council professional standards.

51. The woman missed most of the booked healthcare appointments made for her. There is no suggestion that she lacked the mental capacity to decide whether or not to attend her appointments. Generally, prisoners are responsible for making and keeping appointments as they would be in the community. However, the Head of Healthcare told the clinical reviewer that prisoners who missed several healthcare appointments were referred to the well being team who would discuss their non-attendance with them.

52. A referral to the well being team in such circumstances seems a good iniative to check whether there are underlying reasons for women not attending appointments. Although the woman was seen by the wellbeing team, it is not clear from the subsequent entries in her medical record that her reasons for not attending appointments were fully discussed. Certainly, the entries do not help us to understand why she failed to attend on so many occasions. There is no evidence that she was given any support, reassurance or indeed encouragement to attend appointments. While this might partly be down to inadequate record keeping discussed above, we also make the following recommendation:

    The Head of Healthcare should ensure that when a prisoner is referred to the well being team because they have missed healthcare appointments, reasons for their non-attendance are fully explored and recorded and the prisoner is given appropriate support to encourage future attendance.

Staff response on 9 March

53. The woman's diary entry on Thursday 7 March refers to painful back ache. The next day, she saw a nurse for her daily Subutex dose but did not mention having any back pain or feeling unwell. There is no record of her seeking any medical help that day. At about 4.15pm, she told Officer A about her back pain but declined the offer to be assessed by healthcare staff. According to the evidence we have seen, there were no other indications that she had any health problems in the days before 9 March or that any earlier action could have been taken.

54. At about 10.00am on 9 March, Officer B responded to the woman's cell bell and quickly realised that she was not well. The nurse dispensing medication on the wing immediately stopped that task and went to assess her in her cell. After taking basic observations, she requested an emergency ambulance. The first paramedic arrived at the prison within 15 minutes of the concerns about her being raised and she was in hospital within an hour and half. The clinical reviewer is complimentary about the swift response of both wing officers and healthcare staff to her condition.

Contacting the woman's family

55. At about 10.00am on 9 March, a nurse asked the officers on Oak unit to request an emergency ambulance. The paramedics decided that the woman needed to be taken to hospital and by 12.40pm; the prison knew that she was going to be admitted to the Intensive Care Unit. However, her next of kin, her mother, was not contacted until the hospital considered it necessary later that evening.

56. Prison Rule 22 requires that 'If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed'. We consider that the very fact that an emergency ambulance was called to take her to hospital is indicative that the prison believed she was very ill and her family should have been contacted at that point. At the very latest the prison should have contacted her family when they learned that she was to be admitted to the Intensive Care Unit.

The Governor should ensure that next of kin is notified as soon as possible when a prisoner becomes seriously ill.

The use of restraints

57. 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 and which also takes into account factors such as the prisoner's health and mobility.

58. 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.

59. We have examined the risk assessment completed on 9 March. A Senior Officer (SO) completed the assessment, noting that there were no indications that the woman might try to escape and no recent security information relevant to her risk. The SO recorded that she was on the basic level regime (the lowest) under the prison Incentive and Earned Privileges scheme because of repeated poor behaviour. (Under the scheme, good behaviour is awarded with extra privileges, and poor behaviour results in some privileges being taken away.) A nurse completed part of the assessment and noted that there were no medical objections to her being restrained. There were no indications that she posed a security risk and she was little risk to the public. Nevertheless, she was restrained by an escort chain. The opinion of healthcare professionals about how her medical condition impacted on her risk was not considered as the court judgement requires. An assessment that there is no medical objection to the use of restraints is not the appropriate test. The risk assessment was reviewed the next morning and the duty governor instructed that the restraints should be removed.

60. By mid-afternoon on 9 March, the prison knew that the woman was going to be admitted to the Intensive Care Unit and that she was very seriously unwell. We do not consider that there was a fully considered risk assessment to justify the original decision to use restraints, but in any event the risk assessment should have been reviewed at that point and the restraints should have been removed once the seriousness of her condition was established. We make the following recommendation:

The Governor should ensure that risk assessments for prisoners admitted to hospital fully take into account the prisoner's health and circumstances and are based on the actual risk the prisoner presents at the time.

RECOMMENDATIONS *(service response in italics below)*

1. The Head of Healthcare should ensure that that all record keeping is made in compliance with the Nursing and Midwifery Council and General Medical Council professional standards.

   Accepted:
   - *Record keeping audit to be undertaken – subsequent actions will be dependent on findings*
   - *NMC record keeping guidance for nurses and midwives to be shared with all nursing staff.*
   - *Importance of record keeping to be discussed at staff meetings.*
   - *GMC compliance will be led by a lead GP.*

2. The Head of Healthcare should ensure that when a prisoner is referred to the well being team because they have missed healthcare appointments, reasons for their non-attendance are fully explored and recorded and the prisoner is given appropriate support to encourage future attendance.

   Accepted:
   - *New 'named nurse' model implemented on 25 June 2013 where all residents allocated a nurse for the duration of their stay. This nurse is responsible for holistic are of residents including an oversight of the residents DNA.*
   - *New system in place from August 2013 – named nurses informed of residents who DNA healthcare appointments on more than two occasions in one month and tasked to discuss and document this with them at their next review, to see if any changes can be made to ensure attendance at appointments.*

3. The Governor should ensure that next of kin is notified as soon as possible when a prisoner becomes seriously ill.

   Accepted: *The duty manager will ensure that the next of kin are informed at the earliest opportunity in line with PSI 64/2011*

4. The Governor should ensure that risk assessments for prisoners admitted to hospital fully take into account the prisoner's health and circumstances and are based on the actual risk the prisoner presents at the time.

   Accepted: *Control room and medical escort procedures to be revised to ensure that:*
   - *Current risk assessments are amended to prompt the authorising manager to consider medical advice prior to dispatch of escort.*
   - *Bedwatch documentation to be reviewed to prompt staff to inform duty manager of any changes to prisoner's medical condition.*
   - *Escorting staff to appraise duty governor via control room of prisoner's condition as soon as practical following arrival at hospital.*