



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man on 14 February
2014 while in the custody of HMP Nottingham**

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 man, who died from heart failure on 14 February 2014, while in the custody of HMP Nottingham. He was 31 years old. I offer my condolences to the man's family and friends.

A clinical review was commissioned to investigate the man's clinical care. The prison cooperated fully with the investigation.

The man had a long history of drug dependence and on 7 January 2014, he was sentenced to twelve weeks in prison for breach of a community order. He was sent to HMP Nottingham. When he arrived at the prison a doctor noted that his long term misuse of drugs had impacted on his health. In 2008, and again in 2010, he had undergone heart valve replacement procedures. In 2013, he had a full right hip replacement for which he was taking pain relief. He had been receiving methadone treatment in the community and his methadone prescription continued in prison.

On 26 January, the man had breathing difficulties, and a diagnosis of asthma was made. He had further episodes of shortness of breath over the next two weeks and, on 12 February, he was taken to hospital as an emergency when he reported chest pain in addition to his breathing problems. He was admitted to the intensive care unit, where he died two days later.

I share the clinical reviewer's concern, that the original diagnosis of asthma was not questioned as the man's treatment developed. It should have been recognised earlier that he was not responding as expected and alternatives considered. The clinical reviewer noted that there was a lack of a formalised system for reviewing patients' response to treatment. I am also concerned that staff at Nottingham were not aware of their responsibilities in relation to the use of emergency medical codes. The prison needs to distinguish between incidents when healthcare staff are asked to attend prisoners as a priority and life-threatening situations which require an ambulance to be called immediately.

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. On 7 January 2014, the man was sentenced to 12 weeks in prison for breaching a court order and sent to HMP Nottingham. He had been receiving methadone in the community to treat heroin addiction which was continued. A reception health screen noted that he had undergone two heart valve operations in 2008 and 2010 and a hip replacement in 2013.
2. On 26 January at about 7.30am, a nurse examined the man in response to an emergency call when he had breathing difficulties. She took his clinical observations and asked him to alert staff if his condition worsened. Another nurse reviewed him twice more that morning and referred him to the doctor who noted his chest was clear but his peak flow rate (rate of exhaled breath) was lower than expected. The doctor decided on a working diagnosis of asthma and prescribed a salbutamol inhaler. He increased the dose of methadone.
3. On 28 January, the man again complained of shortness of breath. His observations were normal, apart from a raised heart rate. On 29 January, a nurse responded to an emergency call when he was breathing rapidly. The nurse thought that he was having a panic attack. His observations were normal, apart from an elevated pulse rate. The man's breathing calmed and the nurse referred him to the GP for review. The next afternoon the doctor prescribed steroid tablets, in keeping with a diagnosis of asthma.
4. On 4 February, a doctor noted the man's condition had improved, and prescribed further steroids. On 8 February, a nurse examined him when his breathing was very erratic and his pulse rate was high, but his temperature and blood pressure were normal. Later that day, another doctor observed that the man's condition worsened when he stopped taking steroid tablets so prescribed further steroids and a course of antibiotics. He referred him for a chest X-ray.
5. On 12 February, a nurse responded to an emergency call when the man was having breathing difficulties. He said that he also had chest pain and pointed out that he had had two previous heart operations. The nurse requested an emergency ambulance and gave him oxygen. He was taken to hospital where he had a cardiac arrest. He was put into an induced coma and moved to the intensive care unit. On 13 February, the man regained consciousness and his condition appeared to stabilise. However his condition deteriorated again and he died at 4.35pm on 14 February. His family were with him at the time.
6. The clinical reviewer found that an incorrect diagnosis of asthma was made and not reviewed when the man did not respond to treatment. The clinical reviewer noted that a better diagnosis might not have changed the outcome for the man, but would have ensured his symptoms were more quickly and appropriately treated and relieved his distress. His family believe an earlier diagnosis may have made a difference, he had survived the same condition before. We are concerned at the incorrect use of the emergency code system at the prison and note the need for escorting officers to liaise sensitively with the families of critically ill prisoners. We make four recommendations.

THE INVESTIGATION PROCESS

13. The investigator issued notices to staff and prisoners at HMP Nottingham informing them of the investigation and inviting anyone with relevant information to contact him. One prisoner responded.
14. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. He visited the prison on 21 February 2014 and met the Governor and other staff. He interviewed two members of staff and one prisoner on 27 May. He gave the Governor initial feedback about the preliminary findings of the investigation.
15. NHS England commissioned a doctor to review the man's clinical care at the prison.
16. We informed HM Coroner for Nottinghamshire of the investigation, who provided a copy of the post-mortem report. We have sent the Coroner a copy of this investigation report.
17. One of the Ombudsman's family liaison officers contacted the man's family to explain the purpose of the investigation. She spoke to his mother, sister and partner. His family raised a number of questions and concerns which included:
 - They wanted to know whether he was prescribed appropriate medication.
 - They considered that he had become ill within five days of arriving at the prison and that staff should have identified his illness sooner.
 - They believed that staff had not responded promptly to the man ringing his cell bell and wondered whether it had been switched off. They were also concerned there was a delay in the emergency response on 12 February.
 - His mother said that prison staff said they had been unable to contact her when he was taken to hospital, and that she was given incorrect information about the emergency response. She had first been told that he had been resuscitated at the prison and then that this was not the case.
 - The man's partner was upset that officers had prevented her from showing the man a picture of their son on her phone in his final days and that she had not been allowed any private time with him when he regained consciousness in hospital for one day.
18. The man's family received a copy of the draft report, they asked us to reflect their concern that an earlier diagnosis may have made a difference as he had survived the same condition before. This report has been amended accordingly.

His family also raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP NOTTINGHAM

19. HMP Nottingham is a local prison serving the courts in Nottinghamshire and Derbyshire and holds over 1,000 men.
20. Nottinghamshire Healthcare Trust provides health services at the prison. There is no inpatient unit. Prisoners who need nursing care are located in an enhanced care area on F wing, where nurses are on duty 24 hours a day. Prisoners on detoxification and integrated drug treatment system programmes are supported on A wing.

Her Majesty's Inspectorate of Prisons

21. The most recent inspection of Nottingham was in February 2013. The Inspectorate noted that there was effective joint care planning and reviews between the substance use and psychosocial teams for prisoners with substance misuse problems. Some improvements had been made in healthcare and pharmacy services since the previous full inspection in 2010 when the inspectorate had found that health services were of a good standard and prisoners had good access to health professionals.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its annual report, for the year to March 2013, the IMB noted that the prison had no in-patient care provision and that prisoners requiring that level of care were transferred to the appropriate hospital.

Previous deaths at Nottingham

23. The man's death was the fourth through natural causes since 2010 at Nottingham. We have raised the issue about emergency response before.

KEY EVENTS

24. On 21 November 2013, the man was sentenced to a 12 month community order with supervision with a 12 month drug rehabilitation requirement. He did not comply with the community order and continued to use drugs. On 7 January 2014, he was sentenced to 12 weeks in prison for the breach of a court order. He was sent to HMP Nottingham.
25. A nurse carried out the man's initial reception health screen. He tested positive for methadone and heroin and she referred him to a prison GP. The doctor noted the man was a long term drug user and this had impacted on his health. He had undergone a heart valve replacement procedure in April 2008 and again in October 2010. In 2013, the man had had a full right hip replacement for which he still took pain relief. The doctor noted that the man had previously suffered from sub-acute bacterial endocarditis (areas of infection on the heart valves that spread to other parts of the body). He had been admitted to hospital on 30 December 2013, with pneumonia which had been treated with antibiotics. He took methadone daily and before his imprisonment said he had used heroin and crack cocaine at least three times a week. He went to A wing, the prison's drug and detoxification unit
26. On 8 January, the man's methadone dosage was confirmed with his community pharmacist. A prison GP prescribed 45mls of methadone daily, to be reviewed regularly with a view to reaching the level he had been prescribed in the community (60mls). He also prescribed pain relief for his hip.
27. On 18 January, when the man went to get his pain relief medication from the treatment hatch on A wing, a nurse noted in his medical record that the man had mentioned he had 'heart valve issues'. The nurse listed him to see the GP and a heart disease practice nurse.
28. The man did not attend a substance misuse clinic appointment on 20 January and was sent a reminder. The next day, he did not turn up for a nurse triage appointment. The reasons he did not attend were not recorded.
29. On 24 January, a healthcare assistant carried out an alcohol assessment. The man told her he did not drink alcohol and that he had no outstanding hospital or doctor's appointments. The healthcare assistant noted he smoked cigarettes and his blood pressure was normal.
30. At 7.26am on 26 January, a nurse went to see the man after a code blue emergency was called. (This is an emergency code used when someone has difficulty breathing and requires urgent medical assistance. It should result in an ambulance being called automatically.) He told her he was struggling to breathe. She took his clinical observations. His blood pressure was high, he had a rapid pulse and a high respiratory rate. The nurse advised him to press his cell bell again if his condition got worse and let staff know.

31. A nurse reviewed the man at 9.43am and noted that he was pale and still had a high pulse and respiratory rate, but his blood pressure was within normal limits. He said that he felt generally unwell and short of breath and had been suffering from a headache since the early hours. He said he was coughing up white frothy sputum and had experienced intermittent sharp pain to the tip of his left shoulder. The nurse gave him paracetamol and ibuprofen and arranged for a doctor to see him as soon as possible. At 10.53am, a nurse assessed the man again. He said that he felt better since he had taken his methadone and had smoked a cigarette.
32. At 11.17am, a doctor examined the man and recorded that he was alert, chatty and pleasant. His chest was clear and heart sounds were normal, apart from the sound of the replaced mitral valve. His peak flow rate (expiration rate) was lower than the expected level and the doctor prescribed a salbutamol inhaler (medication to help open airways and ease breathing). The doctor increased his methadone dose to 55mls. The doctor noted a working diagnosis of asthma.
33. On 27 January, a nurse saw the man for a five day drug therapy review. The nurse advised the man he was at risk of an overdose due to lower tolerance levels. She referred him for a follow up substance misuse assessment. Someone from the substance misuse team saw him that afternoon and they agreed a substance misuse clinical management plan.
34. On 28 January, the man attended the nurse triage clinic and said he was suffering from shortness of breath. He said he had no chest pain but had had a cold sweat during the night. A nurse noted he was not sweating but had over-used his salbutamol inhaler and had finished a month's supply in just two days. He was alert and orientated and his observations were normal, apart from a raised heart rate. The man said that he felt sick, which he attributed to methadone. A doctor advised that the man should try an anti-sickness pill, although it is not clear from the records if he saw the man in person.
35. At 9.01am on 29 January, a nurse went to the man's cell in response to another code blue emergency. The man was breathing rapidly and the nurse thought he was having a panic attack. His observations were normal, except his pulse rate was raised. His breathing calmed after several minutes. As the man was already on the respiratory clinic list and was listed for a GP review the nurse took no further action.
36. On 30 January, a nurse assessed the man. She noted he had used one salbutamol inhaler in four days with little effect. She examined him and found that the base of his lungs was wheezy and crackly. His pulse rate was raised and his peak flow was reduced. She arranged for him to see a doctor that afternoon. The man told the doctor that he felt his shortness of breath was worse. The doctor noted the reduction in his peak flow over the previous four days and that his pulse rate was better and within normal range. He prescribed steroid tablets.
37. On 3 February, the man told a pharmacy technician that he felt 70 percent better, but still found it difficult to breathe. A doctor examined him the next day,

- and noted his chest was clear and his peak flow rate had increased. He prescribed a steroid inhaler to be taken with his salbutamol. He noted that the working diagnosis was still asthma.
38. On 8 February, a nurse went to see the man as a landing officer had been concerned about his condition. The man was breathing very erratically, his pulse was elevated but his temperature and blood pressure were normal. A doctor reviewed the man later that day and noted that his condition worsened when he stopped taking steroid tablets. The man's peak flow was reduced, he was not wheezing and there was no cyanosis (blue colouration to skin). The doctor noted a possible diagnosis of sarcoidosis (an inflammatory condition of unknown cause) or pneumonia. He prescribed steroids and a course of antibiotics and referred the man for a chest X-ray. He planned to review him five days later.
 39. On 11 February, a nurse reviewed the man and noted that he still had difficulty breathing but his peak flow had improved. He asked if he could continue with steroids and she placed him on the doctor's review list.
 40. At 12.00pm on 12 February, the man pressed his cell bell and an officer found him struggling to breathe and radioed a code blue. A nurse attended and noted that the man was in distress and indicated he had right-sided chest pain and said he had had two previous cardiac operations. He was clutching his chest and asked for help. The nurse noted his oxygen saturations were low and gave him oxygen. At 12.28pm, the nurse requested an emergency ambulance because she was concerned that he was not improving.
 41. The ambulance arrived at 12.41pm and took the man to the Queen's Medical Centre, Nottingham. Escort officers used single handcuffs to restrain him but removed the handcuffs during the journey, at the request of ambulance staff. The prison's head of operations telephoned the man's partner to inform her that he was being taken to hospital and she went to the hospital. The man was admitted with an initial diagnosis of acute asthma. However, very shortly after he arrived he had a cardiac arrest and was put into an induced coma and transferred to intensive care.
 42. A hospital consultant assessed the man and arranged an urgent echocardiogram (ECG). This showed a severely thickened and abnormal prosthetic mitral valve with a dilated and impaired right atrium (upper chamber of heart) and mild to moderate impairment of his left ventricular function (lower chamber of heart). A scan showed fluid in the membranes covering the lungs and other changes consistent with heart failure. He remained unconscious and on a ventilator.
 43. The man was due to be released from prison on 17 February, five days after his admission to hospital. On 12 February, the prison began the process to release him on temporary licence, including contacting the police and probation service who had no objections. Unfortunately, this was not agreed before he died.

44. At 10.50am on 13 February, the man regained consciousness and his mother and his partner visited him. His partner wanted to show him some photographs of their son on her mobile phone but the escorting officers would not allow her. The man's condition stabilised during the day and hospital staff discussed possible treatments with him.
45. At 3.00am on 14 February, he experienced breathing difficulties and was put back on to a ventilator. He was given supportive care but his condition deteriorated rapidly. Hospital staff contacted his partner who went to the hospital to be with him. The escorting prison officers withdrew from the intensive care unit into a waiting room. The man's mother arrived at about 9.00am and stayed at his bedside with his partner and other family members. He continued to deteriorate and he died that afternoon. A hospital doctor certified his death at 4.35pm.

Liaison with the man's family

46. When the man had arrived at the prison, he had given reception staff handwritten telephone numbers for his mother and partner. Unfortunately, it appears that the person who put the records on the prison's system misread his mother's number and entered this incorrectly. This meant that when he was taken to hospital on 12 February the prison was unable to contact his mother. However, the prison's head of operations contacted his partner and she telephoned the man's mother. Both arrived at the hospital at 2.00pm.
47. The prison appointed a family liaison officer who was at the hospital when the man died. He offered support and guidance to the man's family.
48. The man's funeral took place on 20 March. The prison contributed to the costs of the funeral in line with national guidance.

Support for staff and prisoners

48. Staff and prisoners were informed of the man's death by a Governor's notice which offered support to anyone affected. Prisoners identified as at risk of suicide and self-harm were reviewed in case they had been adversely affected by the news of his death. A debrief was held for the staff who had been involved in his care.

Post-mortem

49. The post-mortem report showed the cause of death as heart failure, myocarditis and pericarditis (inflammation of the heart muscle and its covering); and mitral valve disease with interstitial myocardial fibrosis (abnormal thickening of the heart valves).

ISSUES

Clinical care

50. The clinical reviewer noted that the man was not a well man when he arrived at HMP Nottingham. He had a significant medical history including serious conditions which were potentially life limiting. He had had two heart valve operations as a result of damage caused by his drug use. He had continued to use illicit drugs before he went to prison, despite advice that he could cause further damage to his heart. The outcome would therefore potentially have been the same, whether he was in prison or not. The man's medical history was clearly documented on SystmOne (the computerised medical record) and the clinical reviewer found that standard of record keeping was good practice. While staff were aware of his serious medical history and took this into account, the clinical reviewer noted that if the software had been set up correctly this would have been highlighted under the heading 'major problems' and given all healthcare staff a prompt about potential areas of risk.
51. The clinical reviewer says that although the man's episodes of shortness of breath were accurately assessed and the results of appropriate measurements and observations recorded, an incorrect initial diagnosis of asthma was made. This was not questioned by any of the healthcare staff who saw him as he continued to present with similar symptoms and did not respond as would have been expected to the treatment for asthma. It does not appear that healthcare staff fully took into account that the man thought he had heart problems.
52. The clinical reviewer points out that questioning the initial diagnosis, may have led to an earlier diagnosis of cardiac problems. He says that although it may not have altered the outcome it would have allowed earlier symptomatic treatment and relieved some of the man's evident distress.
53. A doctor explained that the first contact he had with the man was on Sunday 26 January after the early morning emergency code blue call. A nurse had telephoned him and explained the man's medical history and symptoms at the time. The doctor said that as the man had a history of heart problems and was reporting being short of breath, he decided to go to the prison and assess him in person. When he examined him, his presentation indicated asthma and he prescribed accordingly. He said that the prison's health service was nurse led and if he had concerns about any patient he would normally arrange a further appointment or alternatively arrange a nurse review. He said he had considered alternative diagnoses, but felt that asthma was the most likely cause of the shortness of breath and did not consider there was any cardiac causes.
54. The clinical reviewer notes there were no formalised arrangements for follow up appointments and there was a lack of planned care for the man. He points out that it took a total of four code blue emergency calls before a GP assessed the man. We make the following recommendations:

The Head of Healthcare should ensure that SystmOne (the electronic medical record) is set up to highlight relevant medical history so all staff

can see major diagnoses and prompt consideration of potential areas of risk.

The Head of Healthcare should ensure there is appropriate care planning for all prisoners with a significant health history with efficient systems for follow up, including to review their symptoms and medication.

Emergency response

55. Prison Service Instruction (PSI) 03/2013, which was issued at the beginning of February 2013 required governors to have a medical emergency response code protocol based on the instruction by 28 February 2013. This should instruct staff how to communicate the nature of a medical emergency using agreed emergency codes and ensure that the control room calls an ambulance automatically as soon as an emergency code is called. The instruction explicitly states that all prison staff must be made aware of and understand the instruction and their responsibilities during medical emergencies.
56. Staff called an emergency code blue for the man on 26 and 29 January 2014 and 12 February, but the control room did not call an ambulance. Each time nurses went to assess him. On the third occasion a nurse requested an ambulance nearly thirty minutes after the code blue was called. This is directly contrary to the national instruction which makes it clear there should be no delay in calling an ambulance in a medical emergency, which can always be cancelled if ultimately it is not required. A doctor told us that his understanding was the code blue was not necessarily indicative of an emergency and were often used to get nursing staff to attend the wing quicker than they would otherwise. This appears to have been the practice at Nottingham, but it is not a correct understanding of the requirements of PSI 03/2013.
57. On 11 February 2014, following feedback from an investigation into a death at Nottingham in November 2013, about the need for ambulances to be called automatically when an emergency code is called, the Governor issued a local operational instruction advising all staff of the correct procedure for calling a medical emergency. This included the mandatory contingency response that the communication/control room should automatically call an ambulance, when an emergency code is used. However, the day after the instruction was issued it was not followed. On 12 February, an officer called an emergency code blue at 12.00pm, but the control room did not call an ambulance until the nurse requested one, at 12.28pm.
58. We are concerned that despite the operational instruction, staff at Nottingham still did not appear to understand their responsibilities in relation to the use of emergency codes. It is particularly concerning that control room staff responsible for calling an ambulance did not follow the local protocol issued just the day before. It is also worrying that a doctor, who we interviewed in May 2014, told the investigator that it is usual for a nurse or doctor to assess a patient before an ambulance is called. In future emergencies such a delay could be crucial. There needs to be a distinction between situations when

health care staff are asked to attend as a priority and life-threatening emergency incidents. We make the following recommendation:

The Governor should ensure all prison staff understand PSI 03/2013 and their responsibilities during medical emergencies and that an ambulance is requested automatically when an emergency medical code is called.

Cell bells

59. The man's family were concerned that staff did not respond promptly when he rang his cell bell or that it had been switched off. Each time a cell bell is pressed the call is automatically recorded electronically. The record shows the time the bell is pressed and the time it is reset (answered). The investigator checked cell bell records and found that the man had used his cell bell four times. He received an immediate response and healthcare staff attended each time. The man's cell mate confirmed that this was the case.

Family contact

60. When the man regained consciousness on 13 February, his partner was upset that the escorting officers prevented her from showing him a picture of their son on her mobile phone. Prisoners are not usually allowed access to mobile phones but in these circumstances we consider the officers should have acted more compassionately and allowed the man to see the picture of his son. He was critically ill, in intensive care, a low risk prisoner and was due for release four days later, if he was not temporarily released before then. The officers were in the room at the time and able to supervise access.
61. The man regained consciousness on Thursday 13 February and officers remained at his bedside throughout that time. His family were concerned that they were not allowed any private time with him that day. As noted he was not a high risk prisoner and was almost at the point of release. He was very sick and not an escape risk or danger to the public. The night before hospital staff had told his partner that his prospects for survival were very small and it was likely that he would die soon. Although the man's condition had stabilised to the extent that the possibility of cardiac surgery was being considered, the prospects of success were regarded as small.
62. While the man was unconscious, officers had remained in an adjoining waiting room. We consider that when he regained consciousness they should have allowed his family some private time together while he was conscious by waiting outside the room or sought advice from a senior manager if they were uncomfortable about this. It is unfortunate that a decision about the man's release on temporary licence had not been made by this stage which might have helped avoid the situation. We make the following recommendation:

The Governor should ensure that officers accompanying prisoners to hospital understand the supportive aspects of their role as well as security and, where possible, allow family members appropriate private time with prisoners who are critically ill.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that SystemOne (the electronic medical record) is set up to highlight relevant medical history so all staff can see major diagnoses and prompt consideration of potential areas of risk.
2. The Head of Healthcare should ensure there is appropriate care planning for all prisoners with a significant health history with efficient systems for follow up, including to review their symptoms and medication.
3. The Governor should ensure all prison staff understand PSI 03/2013 and their responsibilities during medical emergencies and that an ambulance is requested automatically when an emergency medical code is called.
4. The Governor should ensure that officers accompanying prisoners to hospital understand the supportive aspects of their role as well as security and, where possible, allow family members appropriate private time with prisoners who are critically ill.

ACTION PLAN: A man – HMP Nottingham

No	Recommendation	Accepted/ Not accepted	Response	Target date for completion and Function Responsible
1	The Head of Healthcare should ensure that SystmOne (the electronic medical record) is set up to highlight relevant medical history so all staff can see major diagnoses and prompt consideration of potential areas of risk.	Accepted	SystmOne has now been configured to ensure that the Quality and Outcomes Framework (QOF) read codes are highlighted clearly in patients' records.	Completed Head of Healthcare
2	The Head of Healthcare should ensure there is appropriate care planning for all prisoners with a significant health history with efficient systems for follow up, including to review their symptoms and medication	Accepted	A review of SystmOne waiting lists was completed in January 2014. This has enabled clinicians to ensure that patients receive follow ups as required. Further work with SystmOne is currently underway to implement a 'recall' system so that patients are automatically recalled for an appointment when it is required.	31 December 2014 Head of Healthcare
3	The Governor should ensure all prison staff understand PSI 03/2013 and their responsibilities during medical emergencies and that an ambulance is requested automatically when an emergency medical code is called.	Accepted	A Governor's order was published in February 2014 which makes it clear that the control room is required to call an ambulance for every Code Blue that is received over the net and then ask for updates from the scene after the call has been made. A copy of this order is displayed in the control room and there has been evidence that this process is now operating as per the policy.	Completed

4.	Governor should ensure that officers accompanying prisoners to hospital understand the supportive aspects of their role as well as security and, where possible, allow family members appropriate private time with prisoners who are critically ill.	Accepted	A Notice To Staff will be issued to advise staff to seek advice and authority from the Duty Governor when family members may wish to visit a prisoner on their own.	31 July 2014 Deputy Governor
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