Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Gary Gollaglee a prisoner at HMP Kirklevington Grange on 24 December 2017

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Gary Gollaglee died from a drugs overdose on 24 December 2017 at HMP & YOI Kirklevington Grange. He was 33 years old. I offer my condolences to Mr Gollaglee's family and friends.

Mr Gollaglee had a long history of drug misuse in the community and he had regular contact with substance misuse services and healthcare staff in prison. Other prisoners at Kirklevington Grange told us that they knew Mr Gollaglee was using illicit drugs in addition to his prescribed methadone. However, prison staff said they were not aware of this. The combination of illicit and prescribed drugs produced toxic effects that caused Mr Gollaglee's death.

When Mr Gollaglee was found unresponsive in his room, the emergency response was not in line with national guidance. No first aid trained staff were on duty. Although these failings did not affect the outcome for Mr Gollaglee, Kirklevington Grange need to ensure these deficiencies are addressed urgently.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **August 2018**

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Summary

Events

1. On 14 October 2015, Mr Gary Gollaglee was remanded to custody at HMP Holme House. He was subsequently sentenced to six years imprisonment. He was moved to HMP Northumberland before being transferred to HMP & YOI Kirklevington Grange on 2 November 2017.

2. Mr Gollaglee had a long history of substance misuse in the community and was prescribed methadone (a synthetic opiate used to treat heroin addiction) in prison. He arrived at Kirklevington Grange on a methadone maintenance dose of 30mls. On 15 November, Mr Gollaglee asked to move from maintenance to reduction, and his methadone was reduced by 2mls, every two weeks. At the time of his death, Mr Gollaglee was prescribed 15mls.

3. On the evening of 23 December, Mr Gollaglee was heavily under the influence of illicit drugs but staff were unaware. Prisoners did not tell staff as they did not want him to get into trouble and they did not think he needed medical help.

4. On 24 December, at around 6.10am, a night operational support grade found Mr Gollaglee unresponsive on the floor of his room. Staff and paramedics were unable to resuscitate him and at 6.35am, paramedics recorded Mr Gollaglee had died.

5. The post-mortem report found that Mr Gollaglee had pregabalin (which can be used to enhance the euphoric effects of other drugs such as opiates) and zopiclone (a hypnotic drug used to treat insomnia) in his system, neither of which he had been prescribed. The pathologist considered that, although neither of these were present in fatal quantities on their own, they were likely to have produced toxic effects in combination with the methadone.

Findings

6. There was no information to suggest Mr Gollaglee was using illicit drugs in addition to his prescribed methadone. He had regular support from the drug and alcohol recovery team, and had daily contact with healthcare staff. The clinical reviewer concluded he received a good standard of care, equivalent to that which he could have expected to receive in the community.

7. When the night operational support grade discovered Mr Gollaglee on the floor of his room, she asked her colleague to come and check him. Although they could not get a response from him, neither used their radio to transmit a medical emergency code, but asked for other staff to assist. Both patrol staff remained outside Mr Gollaglee's room until other staff arrived.

8. There were no first aid trained staff on duty, despite this being a mandatory requirement. A portable defibrillator was available, but it was not used as staff did not feel they had had sufficient training.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff use an appropriate code to communicate a medical emergency and that control room staff call an ambulance immediately a medical emergency code is received.
- The Governor should ensure there are sufficient first aid trained staff, at all times, in line with PSI 29/2015.

The Investigation Process

9. The investigator issued notices to staff and prisoners at Kirklevington Grange, informing them of the investigation and asking anyone with relevant information to contact her. Nobody responded.

10. Kirklevington Grange provided the investigator with copies of relevant extracts from Mr Gollaglee's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Gollaglee's clinical care at the prison.

12. The investigator interviewed nine members of staff and three prisoners at Kirklevington Grange on 25 and 26 January. Interviews on 26 January were conducted with the clinical reviewer. She also interviewed a prisoner by telephone on 26 February.

13. We informed HM Coroner for Teesside of the investigation. She gave us the results of the post-mortem examination and we have sent the Coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Gollaglee's family to explain the investigation. Mr Gollaglee's family wanted to know what happened during his time at Kirklevington Grange, but raised no specific issues.

15. Mr Gollaglee's family received a copy of the initial report, but did not identify any factual inaccuracies. They reflected that they found it hard to believe prison staff did not realise Mr Gollaglee was under the influence the night before he died, and were disappointed with the emergency response.

16. The prison received a copy of the report and clarified staff roles, which have been amended. In addition, the prison requested changes to provide clarity, which we have amended.

Background Information

HMP & YOI Kirklevington Grange

17. HMP & YOI Kirklevington Grange is an open prison holding up to 283 Category D adult male prisoners and young male offenders. Healthcare services are provided by G4S, GP services by Spectrum, and non-clinical drugs and alcohol support by Lifeline. Healthcare at Kirklevington Grange is part time Monday – Friday between 8am-1pm and is provided by G4S Forensic and Medical services.

HM Inspectorate of Prisons

18. The report of the most recent inspection of Kirklevington Grange was in January 2015. The inspectors noted although there were some problems with the use of illegal drugs, this was less so than in comparable prisons. Inspectors reported that the drug and alcohol recovery team provided a good service to a relatively small number of prisoners in recovery, but more needed to be done to engage with longer-sentenced prisoners and those who were still using drugs.

19. Health services were found to be generally good but inspectors were concerned to find some emergency equipment was out of date. First aid training had been completed by 24% of custody staff and 8% had been trained in the use of defibrillators. Further training was planned so that appropriately trained staff were present on each shift.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its most recently published annual report for the year ending 31 December 2017, the Board stated that Kirklevington Grange consistently operated at a high level. Illicit drug taking and the trading of medication amongst prisoners was a concern but was being tackled vigorously and new initiatives introduced. The Board was concerned by the way in which prescription drugs were distributed for a number of days at a time to prisoners and the impact this had. Management were investigating the introduction of a recovery work project used with success at HMP Durham.

21. Prisoners were generally safe and violence was extremely unusual. The Board reported substance use was a concern, but that the Drug and Alcohol Recovery Team (DART) had provided good support to prisoners. The Board raised concerns about the increased use of psychoactive substances and the use of tradeable prescription medications.

Previous deaths at HMP Kirklevington Grange

22. Mr Gollaglee is only the second death at Kirklevington Grange. A prisoner died of natural causes in January 2008.

Psychoactive Substances (PS)

23. Psychoactive substances, previously known as ‘new psychoactive substances’ (NPS) or ‘legal highs’, are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

24. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

25. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Key Events

26. Mr Gary Gollaglee was remanded into prison custody at HMP Holme House on 14 October 2015. He was sentenced to six years imprisonment on 3 February 2016, for offences of robbery and having an offensive weapon. He had been to prison before.

27. Mr Gollaglee had a long history of drug misuse, which continued while he was in custody. Mr Gollaglee had attempted multiple methadone detoxifications, but was unable to remain drug free. Although Mr Gollaglee engaged with drug and alcohol recovery team workers (DART) throughout his time in prison there were many recorded incidents of him using various illicit drugs in addition to his methadone and, when not prescribed methadone, he misused illicit Subutex (an opiate substitute).

28. On 20 April 2016, Mr Gollaglee was moved to HMP Northumberland. On 18 January 2017, a prison GP recorded that Mr Gollaglee asked for an increase in his methadone from 30mls to 40mls as he was using psychoactive substances (PS) to help him sleep. Mr Gollaglee told the GP that he was a heavy cannabis user in the community and felt that when he did not use PS he could not sleep and had bad dreams. He felt that if he had his methadone increased to 40mls this would help him to stop using on top of his methadone prescription. His methadone was increased. (Mr Gollaglee started a 28 day reduction of 5mls on 10 March, which was reduced by a further 5mls on 7 April, to 30mls.)

29. On 25 October, Mr Gollaglee was recategorised to security category D, and became eligible to transfer to open conditions.

Kirklevington Grange

30. Mr Gollaglee was transferred to Kirklevington Grange on 2 November 2017, and arrived around 3.45pm. He should have attended a full induction talk but did not report as instructed; an officer spoke to Mr Gollaglee and recorded ‘his induction talk was short and he has not had a phone call’. An Operational Support Grade (OSG) noted that he spoke to Mr Gollaglee at 9.18pm, who said he had no issues. A Physical Education Instructor Senior Officer (PEISO) delivered the gym induction talk the next day.

31. On 3 November, a nurse completed a health screen at 11.18am. She recorded Mr Gollaglee had no physical health needs, although he was prescribed medication for heartburn and indigestion (lansoprazole). Mr Gollaglee had no contact with mental health services during his sentence, although his mental health was regularly considered by healthcare staff and substance misuse workers. He was referred to the DART team.

32. A worker from DART met Mr Gollaglee on 15 November. He had been on a maintenance dose of 30mls methadone, as part of an opiate substitution programme, but told her that he wanted to reduce his methadone. A nurse prescriber agreed the change and Mr Gollaglee started reducing his methadone from 27mls, by 2mls every two weeks.

33. On 20 November, an offender supervisor (responsible for his sentence planning and liaising with external probation services) met Mr Gollaglee. She recorded that he presented with a laissez-faire attitude, although was not rude or impolite. Mr Gollaglee told her he used cocaine and heroin heavily in the community, but that he had good support from his family and that he was on a methadone reduction programme.

34. Healthcare staff engaged with Mr Gollaglee every day when he collected his methadone. The DART worker met Mr Gollaglee on 21 November, when she completed a comprehensive review of his recovery compact and reduction plan. Mr Gollaglee reported no problems, said he enjoyed his work and he continued his two weekly reducing methadone regime (his last recorded methadone prescription was 15mls on 18 December 2017).

35. An officer was assigned as Mr Gollaglee's personal officer (personal officers should get to know the prisoners they are responsible for, act as a first point of contact for any problems, help with resettlement issues and make regular entries in their records about their progress). They met for the first time on 24 November, and the officer recorded that Mr Gollaglee had not had the best start at Kirklevington Grange as he had received a couple of negative entries about a lack of motivation when he first arrived, but in the past few weeks had worked well.

36. An officer placed Mr Gollaglee on report on 29 November, as he caught him smoking a cigarette in the corridor of B Wing. Mr Gollaglee pleaded guilty at his adjudication hearing on 1 December, and told the adjudicator that he could not sleep. 50% of his earnings over seven days was stopped as a punishment. The personal officer met with Mr Gollaglee on 14 December, and encouraged him to stay out of trouble. This was the last entry on Mr Gollaglee's prison record.

37. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. The investigator listened to Mr Gollaglee's calls made from Kirklevington Grange. In total he made 45 calls, a total of nearly 92 minutes and spoke regularly to his family. He told his family he enjoyed being at Kirklevington Grange and that he was keeping out of trouble and not taking any drugs.

23 December - 24 December

38. There is no Closed-Circuit Television (CCTV) on B Wing and, at the time, staff at Kirklevington Grange were not issued with body worn video cameras. On B wing where Mr Gollaglee lived, a roll check (a count of all prisoners) is completed by the evening staff around 8pm, which is handed over to the night staff and then the next roll check is scheduled for around 6am. Prisoners can associate and use the kitchen, but are expected to be in their own rooms, with the doors closed, by 10.30pm.

39. Two OSGs started their night shift around 8.45pm. OSG 1 worked in the gate and did not go over to the residential units during the night, and OSG 2 was assigned as a patrol officer on the residential wings. OSG 2 said she checked A Wing and B Wing and spoke to prisoners on both. She said her main duty when she started her shift was to check the fire doors.

40. Prisoner A, who lived in the room next door to Mr Gollaglee, told the investigator that Mr Gollaglee was popular with other prisoners and was well known as he was the wing barber (although this is not an official position, it is common for prisoners to cut each other's hair). He said it was well known to other prisoners that Mr Gollaglee used other drugs on top of his methadone and was often under the influence. He said on the evening before he died, Mr Gollaglee was heavily under the influence and worse than he had ever seen him.

41. Another prisoner said he met Mr Gollaglee in the kitchen during the evening. He said even though he did not know Mr Gollaglee well, he appeared under the influence and was evidently 'on something'. He said other prisoners were also in the room and that Mr Gollaglee was bragging that he had taken zopiclone and pregabalin, medication he had not been prescribed.

42. Prisoner A said sometime after the roll check at around 8pm, he heard a loud noise from Mr Gollaglee's room when he knocked over his toiletries. He said he went into Mr Gollaglee's room, where he found him trying to pick them up. It was then that he noticed 'how smashed he appeared…he was obviously away with the fairies'. He said because of the noise, other prisoners noticed and they were concerned that Mr Gollaglee would get in trouble from prison staff if they became aware he was under the influence, which could potentially mean him being transferred back to closed conditions. He said in prison 'when you're friendly with someone is you don't report him; people don't grass on other prisoners'. Nobody considered Mr Gollaglee needed medical attention.

43. When OSG 2 went past Mr Gollaglee's room, while she was checking the fire doors, she noticed him particularly as he was wearing a big woolly hat and appeared to be looking at the wires on his television and thought perhaps he needed his television replacing if it was broken. She said she asked him if he was alright, and then became aware Prisoner A was in the room. She said he then left the room. She established there was nothing wrong with Mr Gollaglee's television and she told him to take his hat off because it was hot in the room. She said Mr Gollaglee removed his hat and she had no concerns about him; she did not have any suspicion that he was under the influence.

44. Prisoner B, who lived in the room diagonally opposite Mr Gollaglee, said it was evident he was under the influence and was walking around wearing a big coat and woollen hat. He said he recalled a member of staff asked him if he was okay around 10.30pm, when prisoners were expected to shut their doors for the night, and Mr Gollaglee had said he had taken his methadone (which was administered that morning around 8am). He said Mr Gollaglee was playing his music loudly and other prisoners were telling him to be quiet.

45. Prisoner B told the investigator he went to the toilet at around 11.45pm, and when he returned to his room, Mr Gollaglee's light was on and his door was open so he went to check on him. He said he was asleep on the floor, face down and snoring loudly, but he could not wake him up. He said that he presumed Mr Gollaglee was okay because he was snoring, so he moved him onto his side, similar to the recovery position, and put a pillow under his head thinking that he would wake up in an hour or so and get on his bed himself. He closed the door to Mr Gollaglee's room so he would not get into trouble.

46. Prisoner A also said Mr Gollaglee was snoring loudly and he went in to check on him several times. He said he was annoyed that Prisoner B had closed his door, preventing him from checking him, but said he understood he did this to stop Mr Gollaglee from getting into trouble. He said he heard Mr Gollaglee snoring loudly for some time before he fell asleep and assumed he was fine.

47. Both OSGs were responsible for completing a roll check on residential wings which they started around 6am. OSG 2 said typically they would check wings together, but had decided to take separate wings; she checked A Wing and OSG 1 checked B Wing.

48. At around 6.10am, OSG 1 opened Mr Gollaglee's door and found him on the floor on his front with his head under the bed. She could not see him breathing and could not raise a response from him; she did not touch Mr Gollaglee. She said 'It looked strange and it looked unusual but sometimes I've seen them [prisoners] like sleep on the floor'. She closed the door and went to A Wing, a short distance away, and asked OSG 2 to check Mr Gollaglee with her. They returned to his room and OSG 2 tried to raise a response from him. When she could not she used her radio to call for assistance. They waited outside Mr Gollaglee's room for their colleagues to arrive.

49. Two officers responded to the request for assistance and arrived at Mr Gollaglee's room within a few minutes. One officer tried to get a response from Mr Gollaglee but could not and, with the help of his colleague, pulled him out from under the bed, checked for a pulse and started cardiopulmonary resuscitation (CPR). The other officer described Mr Gollaglee as being warm and clammy, but said it was probably because of the heat from the pipes near where he was lying. He thought Mr Gollaglee was already dead.

50. A Senior Officer (SO), the operational night manager, asked over the radio if an ambulance was required. She recorded on the control room record Mr Gollaglee was found unresponsive at 6.10am. While one officer continued CPR, the other went to the control room to provide her with a verbal update and an ambulance was requested. He said he did not want to give details over the radio as it was an open network which prisoners could hear.

51. According to the control room records made by the SO, an ambulance was requested at 6.13am. North East Ambulance Service records confirm they received a request for an emergency ambulance at 6.14am. Staff continued CPR until paramedics attended and took over. Paramedics arrived at Kirklevington Grange at 6.25am and arrived at Mr Gollaglee's room a minute later. They were unable to resuscitate him and at 6.35am, they recorded he had died.

Contact with Mr Gollaglee's family

52. A family liaison officer (FLO) and his assistant, a prison chaplain, visited Mr Gollaglee's parents. They arrived at Mr Gollaglee's father's address at 11.50am, but the police had already informed him and he told the FLOs he had already informed Mr Gollaglee's mother. They visited Mr Gollaglee's mother at 12.20pm. Kirklevington Grange contributed towards the costs of Mr Gollaglee's funeral, in line with national instructions.

Support for prisoners and staff

53. After Mr Gollaglee's death, a prison manager debriefed the prison staff involved in the emergency response. He offered his support and that of the staff care team.

54. The prison posted notices informing other prisoners of Mr Gollaglee's death, and offering support. A well-attended memorial service was held on 17 January, in the prison chapel.

Post-mortem report

55. During the post-mortem a package was found hidden in Mr Gollaglee's rectum. Police forensically examined the package and confirmed that it contained 18 pregabalin tablets. Pregabalin is prescribed for epilepsy, anxiety and nerve pain, and is a medication that is traded illicitly and abused in prisons. Toxic effects include respiratory depression (slow breathing) and seizures. A toxicology report identified Mr Gollaglee had used pregabalin before his death (or it had been absorbed into his system from the package inserted into his rectum) and was within the range associated with some toxicity.

56. Mr Gollaglee had a higher concentration of zopiclone in his system than the range associated with a therapeutic dose, and it was within the range associated with toxicity. He had not been prescribed zopiclone which is a hypnotic drug prescribed for the short-term treatment of insomnia, and is also abused.

57. Methadone levels were found to be within the range associated with moderate to relatively high therapeutic use. Toxic effects of methadone include respiratory depression and low blood pressure (hypotension) which can lead to coma and death. The toxicology also indicated a low concentration of morphine, which is an opiate (diamorphine is the illicit form known as heroin), although use before Mr Gollaglee's death was not conclusively confirmed.

58. The pathologist concluded that although Mr Gollaglee's blood concentration of pregabalin, zopiclone and methadone were each below the range that could individually have caused a fatal outcome, the interaction between these drugs would have been significant and their sedative and toxic effects would have been enhanced in combination.

Findings

Management of Mr Gollaglee's substance misuse

59. Mr Gollaglee met the criteria for open conditions before he transferred to Kirklevington Grange. The prison has policies appropriate to an open prison in respect of drug testing and searching. We are satisfied that they are sufficiently well implemented. Mr Gollaglee's behaviour at Kirklevington Grange did not draw attention to his continuing drug use. We are concerned at that, but in the circumstances, do not criticise the prison for failing to identify his continuing use of illicit drugs.

60. Mr Gollaglee had misused drugs for many years, despite having attempted several methadone detoxifications. He was seen regularly by DART workers, throughout his time at various prisons. Substance misuse records often noted that he used illicit drugs in addition to his prescribed methadone.

61. During his time at Kirklevington Grange, however, nobody from DART or healthcare who had contact with Mr Gollaglee had any suspicion that he was under the influence or using illicit substances in addition to his methadone. Substance misuse and healthcare records were comprehensive. Staff responded to Mr Gollaglee's request to reduce his methadone, and continued to provide him with regular support. The clinical reviewer concluded Mr Gollaglee received a good level of care, equivalent to that which he could have expected to receive in the community.

Emergency Response

62. PSI 3/2013, *Medical Emergency Response* requires prisons to have a medical emergency response code protocol, which states how staff should communicate the nature of a medical emergency, and that the control room calls an ambulance immediately when a code is used.

63. Kirklevington Grange's local protocol is clear that an ambulance should be called immediately when a medical emergency code is radioed, in line with PSI 3/2013.

64. When OSG 1 found Mr Gollaglee unresponsive on the floor of his room, she alerted her colleague to the fact. OSG 2 also tried to rouse Mr Gollaglee by shouting his name, and then used her radio to request assistance. Neither OSGs radioed an emergency medical code which would have triggered the automatic calling of an ambulance and ensured that responding staff were aware of the nature of the emergency. OSG 1 said she panicked and her colleague said she did not use a code as she did not know what was wrong with Mr Gollaglee, although she knew he was unresponsive. Other prison staff responded immediately to their request for assistance.

65. An officer informed the night orderly officer that an ambulance was required. The ambulance service confirmed they received a request for an ambulance 6.14am, around four minutes after Mr Gollaglee was first discovered. Staff continued CPR until paramedics arrived, but they were unable to resuscitate him.

66. Those staff interviewed, and others the investigator spoke to during her visit, said medical emergency codes are hardly ever used at Kirklevington Grange. Staff did not appear to understand the mandatory requirements set out in PSI 3/2013.

67. A safer custody officer told the investigator that they intended to distribute ERIC cards (emergency response in custody) as a reminder for all staff to use a medical emergency code and to provide OSG staff who undertake night duty with first on scene training. Although Kirklevington Grange have identified the issues with the emergency response, the planned additional training needs to be completed. Any delay in requesting an ambulance could be crucial, and we make the following recommendation to ensure national guidance is followed:

The Governor and Head of Healthcare should ensure that staff use an appropriate code to communicate a medical emergency and that control room staff call an ambulance immediately a medical emergency code is received.

First Aid Training

68. PSI 29/2015, *First Aid* requires there are suitably trained first aiders available to treat anyone who becomes ill in the prison. The PSI states that '*first aid provision must be adequate and appropriate in the circumstances'.* This means that sufficient first aid equipment, facilities and personnel need to be available at all times.

69. Kirklevington Grange do not have healthcare cover during the night. None of the staff on duty when Mr Gollaglee was discovered were first aid trained. Although a defibrillator was available prison staff did not use it as they were not trained in its use. HMI Prisons identified the need for sufficient defibrillator training during their inspection in January 2015.

70. Notices were displayed around the prison of those staff who were first aid trained, but they were very out of date. All custodial managers were first aid trained in 2013, as it was thought that they would be carrying out the role of night orderly officer. However, this did not happen and the role of night orderly officer continued to be carried out by the Senior Officer grade. Kirklevington Grange have failed to ensure there is sufficient first aid cover.

71. Paramedics recorded Mr Gollaglee had hypostasis (blood pooling) on his cheek and his body temperature was cold, all signs that he had been dead for some time, so resuscitation would not have been successful. However, it is imperative there is always first aid cover and that Kirklevington Grange comply with national guidance. We therefore make the following recommendation:

The Governor should ensure there are sufficient first aid trained staff, at all times, in line with PSI 29/2015.

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