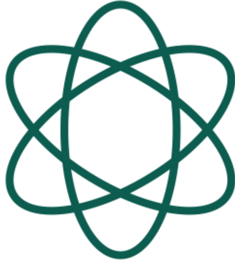
Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alexander Boast, a prisoner at HMP The Verne, on 10 August 2020

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100

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 Alexander Boast died of a heart attack on 10 August 2020 while a prisoner at HMP The Verne. He was 72 years old. I offer my condolences to Mr Boast's family and friends.

Mr Boast had been at The Verne for around fifteen months before his death. During that time his health steadily deteriorated. He was assessed and treated by healthcare staff at The Verne and by doctors at Dorset County Hospital who he saw for a number of health issues.

The clinical reviewer was satisfied that overall the care Mr Boast received at The Verne was equivalent to that which he could have expected to receive in the community. However, the clinical reviewer was concerned that healthcare staff did not recognise that Mr Boast's abnormal clinical observations on 9 August might have indicated significant clinical disease. These observations were not repeated and only a general handover was given to prison staff.

I am concerned that the emergency response on 10 August did not follow prison policy and there were delays in calling an ambulance. I am also concerned that there was no cell bell facility for Mr Boast despite his known health and mobility issues.

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

Sue McAllister CB
Prisons and Probation Ombudsman **April 2021**

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Summary

Events

1. In March 2015, Mr Boast was sentenced to 15 years in prison for sexual offences. On 15 May 2019, he transferred to HMP The Verne.

2. Mr Boast had a number of significant health issues and his health steadily deteriorated in the 15 months that he was at The Verne. While there, he received treatment and medication for long-term heart, lung and kidney conditions.

3. At around 3.50pm, on 9 August 2020, Mr Boast was found shaking by prisoners and staff. Healthcare staff attended and carried out a clinical assessment which showed abnormal results. They left the unit around 5.00pm, before going off duty at 6.00pm, and asked prison officers and his residential support assistant (RSA), another prisoner, to keep an eye on him.

4. Mr Boast's RSA checked on him hourly until around 9.00pm when Mr Boast went to bed. The night officer checked on Mr Boast sometime between 10.30pm and midnight.

5. At around 6.10am on 10 August, the RSA found Mr Boast in his bed struggling to breathe. The RSA alerted staff who attended and called an ambulance. Paramedics arrived at 6.36am. Mr Boast was taken by ambulance to Dorset County Hospital where he died at 9.39am.

6. The post-mortem report concluded that Mr Boast died from a heart attack.

Findings

7. The clinical reviewer concluded that the health and social care that Mr Boast received at HMP The Verne was of a reasonable standard and equivalent to that which he could have expected to receive in the community.

8. The clinical reviewer found that there were, however, some shortcomings in Mr Boast's care.

9. The clinical assessment of Mr Boast on the afternoon of 9 August 2020, showed a pulse rate, blood pressure and oxygen saturation that were abnormal compared to his usual clinical state. Although a NEWS2 score was calculated, healthcare staff failed to recognise that these observations might have indicated significant clinical disease. The observations were not repeated after a period of time to assess for improvement or deterioration.

10. The clinical reviewer also found that the quality of the handover by healthcare staff to prison night staff on 9 August did not give any specific instructions about what prison staff should look for if Mr Boast's health deteriorated or provide any guidance for when to call 111 and when to call 999.

11. Care plans for Mr Boast's chronic health conditions had not been filed in the appropriate Care Plan section of SystmOne (the electronic medical records).

12. We are concerned that Dorset Unit (the dormitory unit where Mr Boast lived at The Verne) has no cell bells in the cubicles. Mr Boast's options for getting help were either to call out or bang on the partition wall in the dormitory to get staff or another prisoner's attention. This might not have been possible for someone in significant health distress particularly at night when other prisoners would be asleep.

13. Prison staff did not call an appropriate medical emergency code in line with prison policy and there were delays in staff calling an ambulance.

Recommendations

- The Head of Healthcare should ensure that healthcare staff know how to respond to lower/abnormal observation results and NEWS2 scores.
- The Head of Healthcare should ensure that when a prisoner's health is causing concern, healthcare staff give prison staff detailed and specific guidance in handovers, including the required frequency of observations, signs of deterioration to look for, and when to seek advice from 111 or to ring 999.
- The Head of Healthcare should ensure that care plans for long-term conditions are appropriately stored in the correct section of SystmOne.
- The Governor and Head of Healthcare should ensure that prisoners on Dorset Unit, especially those who are ill or immobile, have a personal and immediate means of alerting staff if they are feeling unwell or need healthcare assistance.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies in line with Prison Service Instruction (PSI) 03/2013. In particular, where there are serious concerns about the health of a prisoner, staff should use an emergency code immediately to alert control room staff to call an ambulance automatically.
- The Head of Healthcare should share this report with Nurse A and the senior healthcare assistant and discuss the Ombudsman's findings with them.
- The Governor should share this report with Officer A, CM A and the OSG who was the Communications Room Operator on the morning of 10 August 2020 and ensure that a senior manager discusses the Ombudsman's findings with them.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP The Verne informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

15. The investigator wrote to The Verne on 13 August 2020. He obtained a range of documents including copies of relevant extracts from Mr Boast's prison and medical records.

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

17. The investigator and clinical reviewer jointly interviewed six members of staff and one prisoner on 18 and 29 September 2020. All the interviews were conducted by telephone because of the restrictions imposed in response to the COVID-19 pandemic.

18. We informed HM Coroner for Dorset of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

19. The Ombudsman's family liaison officer contacted Mr Boast's next of kin, his wife and daughter, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Boast's wife asked:

    - what medication Mr Boast received in the prison;
    - was there any discontinuation of medication;
    - might this have played a part in his death; and
    - whether prison healthcare staff looked after him properly?

    Her questions have been addressed in this report. Mr Boast's wife and daughter asked for a copy of our report.

20. Mr Boast's family received a copy of the initial report. They did not make any comments.

21. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP The Verne

22. The Verne is a medium security prison for 580 men convicted of sexual offences.

23. The healthcare department is staffed between 7.30am and 6.00pm. Outside those hours prison staff call either the emergency services for an ambulance, or the NHS 111 telephone line for health advice, depending on the prisoner's need. There is no inpatient facility.

24. Dorset Unit is the only dormitory accommodation. The unit consists of 10 ground-floor dormitories and is largely used to house residents with mobility issues or other social care needs. The dormitories are divided into wooden cubicles which provide a level of privacy.

HM Inspectorate of Prisons

25. The most recent inspection of HMP The Verne was in February 2020. Inspectors reported that the prison was performing well in terms of safety and decency and reasonably well in rehabilitation and release planning.

26. The inspectors reported some concerns about healthcare provision. They found that many aspects of the health service were stretched and under-resourced to meet the needs of an ageing population with increasing and complex health issues.

27. The inspectors also noted that prisoners in the Dorset Unit said that the unit enabled them to improve their health and social well-being. They found that Dorset Unit provided excellent care and that nurses were supportive. In addition, Residential Support Assistants (RSAs) were trained and overseen by prison staff to assist prisoners needing additional support with daily living activities.

Independent Monitoring Board

28. 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 latest annual report, for the year to July 2019, the IMB did not raise any concerns about healthcare.

Previous deaths at HMP The Verne

29. Mr Boast was the second prisoner to die at The Verne since August 2018. Since Mr Boast's death, there have been six further natural causes death at the prison.

Residential Support Assistants (RSAs)

30. Residential Support Assistants (RSAs) provide prisoner peer support in line with Prison Service Instruction (PSI) 17/2015, Prisoners assisting other prisoners. RSAs are prisoners trained to provide care and support to older and/or disabled prisoners. Prisoners are vetted by prison staff to work as RSAs and complete a range of

training courses. RSA tasks include getting meals, helping with cell cleaning and tidying, and limited personal care. RSAs do not provide intimate care. They are not medically trained and do not provide waking night cover. RSA are trained to raise health concerns with prison staff about those they assist.

Key Events

31. On 19 March 2015, Mr Boast was sentenced at Lewes Crown Court to 15 years imprisonment for sexual offences. He was sent to HMP High Down and subsequently spent time at other prisons. On 15 May 2019, he transferred to The Verne.

2019

32. On arrival at The Verne, Mr Boast was located on Dorset Unit, a dedicated unit with an accessible environment for prisoners with reduced mobility and social care needs.

33. At his reception health screening, Mr Boast was seen by a nurse. His long-term medical conditions, including hypertension and COPD, were noted. Angina (chest pain that occurs when the blood supply to the muscles of the heart is restricted) and atrial fibrillation (a condition which can cause an irregular and often abnormally fast heart rate) were also noted. He was referred to the prison GP and his medication was reviewed. The next day he was seen by a prison GP.

34. In July, routine blood tests showed that Mr Boast had chronic kidney disease and he was referred for an ultrasound scan of his kidneys and to the nephrology (kidney) department at Dorset County Hospital.

35. On 2 September, Mr Boast had a comprehensive health review on his long-term conditions. Care plans were created for hypertension, cardiovascular disease (a group of conditions affecting the heart and/or blood vessels), COPD and asthma.

36. On 10 September, Mr Boast complained of chest pain and was taken to hospital. He was prescribed digoxin (a medication used to treat irregular heartbeats) and was referred to the cardiology department at the hospital.

37. Mr Boast's health continued to deteriorate. In late September, he was found to be anaemic (a deficiency of healthy red blood cells) and had crackling in his lungs. Blood tests in October showed that his kidney function was deteriorating. The same month he had a comprehensive review of his chronic medical conditions. It was noted that his COPD was worsening, and he was experiencing more shortness of breath.

2020

38. In January 2020, Mr Boast had appointments with cardiology and nephrology specialists at the hospital. Peritoneal dialysis (a treatment to remove waste products from the blood when the kidneys cannot) was discussed as a possible treatment for his chronic kidney disease. Prison healthcare staff said that they would be able to deliver dialysis at the prison. They reviewed Mr Boast's medication and prescribed oramorph (a painkiller) for his worsening back pain.

39. In March, restrictions began to be imposed in response to the COVID-19 pandemic. As a result, several of Mr Boast's hospital appointments were cancelled. This

included his care review appointments in the nephrology and urology (urinary tract) departments. In April, his respiratory review was also cancelled.

40. On 30 March, Mr Boast was given a letter advising him to shield in response to the COVID-19 pandemic and the prison offered him an alternative regime which included 12 weeks of shielding. The Dorset Unit at the prison became a COVID-19 shielding unit.

41. In May, Mr Boast had his rescheduled appointments with respiratory and nephrology specialists by telephone. At the appointment with the respiratory specialist on 19 May, Mr Boast was noted to have pulmonary hypertension (a serious condition that can damage the heart) and oxygen treatment was considered a possibility. They discussed a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) order with him, which meant that if his heart or breathing stopped he would not be resuscitated. At the nephrology appointment, dialysis was discussed in view of his steady decline. On 2 June, at a further nephrology appointment, it was decided to delay dialysis until after a course of steroids to try to improve Mr Boast's kidney function.

42. A review on 22 June showed that the steroid medication had improved Mr Boast's kidney function. However, on 26 June, prison healthcare staff spoke with the nephrology team at the hospital because Mr Boast had ankle oedema (swelling). The nephrology department told prison healthcare staff that his steroid medication should be reduced immediately, and the pantoprazole medication (for acid reflux) should be stopped because they could be causing the swelling.

43. After a further telephone appointment in July, Mr Boast received injections to treat the anaemia caused by his poor kidney function. On 20 July, his steroid medication was further reduced to alleviate the ankle oedema.

44. On 28 July, Mr Boast's wife, his daughter and his granddaughter came to the prison for a specially arranged compassionate visit for Mr Boast to tell his family about his health. The visit had been organised and facilitated by a chaplain. A nurse attended the visit to help Mr Boast describe the changes in his health and his diagnoses over the previous months.

45. Mr Boast and his family discussed a DNACPR order and Advance Directive care (a living will) planning. No decision was made, and the nurse told Mr Boast it was not a decision that should be rushed. She said she would discuss this with him again in the near future.

46. By early August, it was noted Mr Boast had severe oedema of his legs but that the course of steroid medication was coming to an end. It was hoped that this would reduce the swelling.

Events of 9 August 2020

47. In the morning, a healthcare assistant (HCA) saw Mr Boast for his regular clinical examination. She noted that he was continuing to gain weight and his legs were swollen and oozing fluid. She applied cream and told him that if his legs became more uncomfortable, he should go to the unit office and they would ring the healthcare unit for assistance.

48. At 3.00pm, Mr Boast rang his wife from a phone on Dorset Unit. At 3.30pm he rang a friend. At around 3.50pm, Mr Boast's residential support assistant (RSA), and several other prisoners found him shaking, sitting on his wheeled walker by the unit telephones. They alerted staff.

49. Two officers attended. As it was the start of the afternoon medication service on Dorset Unit, Nurse A and a senior HCA arrived on the unit and went to see Mr Boast. With the assistance of the RSA, they helped Mr Boast back to his cubicle. He was shaking and struggling to breathe.

50. Nurse A and the senior HCA assessed Mr Boast. They took some observations, but they were hampered as he was shaking so much. Nurse A gave him paracetamol and they asked an officer to sit with him. During this time, Mr Boast was only able to maintain brief conversations due to his shortness of breath.

51. At around 4.45pm, Nurse A and the senior HCA assessed Mr Boast using the National Early Warning Score (NEWS2 - a tool to measure clinical deterioration and an important tool to improve patient outcomes). His NEWS2 score was 4. The readings taken for the NEWS2 score showed that his oxygen saturation, his blood pressure, and his pulse were all abnormal compared to his usual clinical state.

52. The senior HCA told Mr Boast to speak to prison staff if he did not feel well. At interview the senior HCA said that Mr Boast was alert and was making light of the swelling in his legs. She said that he seemed himself.

53. At around 5.00pm, healthcare staff left Dorset Unit and gave the prison staff, including the officer, a general handover. They also spoke to Mr Boast's RSA. They told them to keep an eye on Mr Boast and call 111 or 999 if he deteriorated. The officer made a written note in the Wing Observation book and on Mr Boast's NOMIS prison record. These notes also indicated that prisoners on Dorset Unit had been told to let staff know if Mr Boast's condition worsened.

54. At interview, the RSA said that the healthcare staff told him to check on Mr Boast and report any deterioration to staff immediately. He said that he would check on Mr Boast anyway, as his RSA.

55. At 5.30pm, two officers finished their shift, leaving one officer on duty on Dorset Unit until the night officer took over around 8.00pm.

56. The RSA supported Mr Boast through the early evening and checked on him every hour. He said that Mr Boast seemed fine through the evening. Sometime between 8.30pm and 9.00pm, Mr Boast told his RSA that he was going to sleep and that he felt alright. The RSA told Mr Boast to bang on the wall of his cubicle if he needed anything.

57. Officer A came on duty at around 8.00pm to start the night shift on Dorset Wing and received a handover from the other officer. He received the same general handover that had taken place around 5.00pm. He also read the Wing Observations book entry about Mr Boast.

58. At interview, Officer A said that he checked on Mr Boast during his night shift. He said he looked into Mr Boast's cubicle sometime between 10.30pm and midnight and saw and heard Mr Boast breathing and asleep.

Events of 10 August 2020

59. At around 6.10am, the RSA awoke and heard Mr Boast groaning in his cubicle in the dormitory. He went into Mr Boast's cubicle and found him partly out of bed and struggling to breathe. He asked another prisoner, to go to the unit office and alert Officer A. The RSA and another prisoner lifted Mr Boast back into his bed.

60. Officer A waited for another officer to arrive at Dorset Unit before they entered the dormitory at around 6.20am. They found Mr Boast gasping for breath and Officer A immediately called Custodial Manager (CM) A. They agreed that Mr Boast needed an ambulance. Officer A then rang the Communications Room operator, an Operational Support Grade (OSG), and asked her to call the ambulance. The OSG logged the call from Officer A and rang 999 around five minutes later.

61. The South West Ambulance Service despatched an ambulance which arrived at the prison at 6.36am. The paramedics assessed Mr Boast and administered drugs to aid breathing. At 7.24am, the ambulance left the prison, and took Mr Boast to Dorset County Hospital. The ambulance arrived at the hospital at 7.53am.

62. At around 9.00am the hospital rang the prison to tell them that Mr Boast was seriously ill and might die that day. At 9.39am, Mr Boast died at Dorset County Hospital.

Contact with Mr Boast's family

63. On 29 July, following the visit from Mr Boast's family, the prison appointed a chaplain as the prison's Family Liaison Officer (FLO).

64. On 10 August, the FLO rang Mr Boast's wife at 9.35am, to tell her that Mr Boast had been taken to hospital. He told her that the hospital had serious concerns about his health and that he might be close to death.

65. At 9.55am, the FLO rang Mr Boast's wife again to inform her that Mr Boast had died. He then rang Mr Boast's daughter to tell her that her father had died.

66. At 2.00pm, the FLO and a senior manager, visited Mr Boast's wife at her neighbour's house. Over the following days, the FLO provided support to Mr Boast's family.

67. The prison offered a contribution to the costs of Mr Boast's funeral in line with national guidance.

Support for staff and prisoners

68. On 10 August, after Mr Boast's death, a CM debriefed the staff involved in the emergency response. Later that day, the same CM debriefed the officers who staffed the escort to hospital and were present when Mr Boast died. Both debriefs took place to ensure staff had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support over the following days.

69. Prison staff debriefed all RSAs and Listeners, and then all prisoners on Dorset Unit. On 11 August, prison staff followed this up with welfare checks for all prisoners on

Dorset Unit. The prison posted notices informing other prisoners of Mr Boast's death and offering support.

Post-mortem report

70. The Coroner concluded that Mr Boast died from a recent heart attack caused by ischemic heart disease (also called coronary heart disease, a condition which restricts the flow of blood and oxygen in the heart) and atherosclerosis (the build-up of substances on the artery walls).

Findings

Clinical Care

71. The clinical reviewer concluded that overall the care Mr Boast received at The Verne was equivalent to that which he could have expected to receive in the community.

72. The clinical reviewer found that there were, however, some concerns about Mr Boast's care, particularly on the day before his death.

Clinical assessment

73. On the afternoon of 9 August 2020, Mr Boast was clinically assessed after being found shaking and struggling to breathe. His pulse rate, blood pressure and oxygen saturation were abnormal compared to his usual clinical state. Although a NEWS score was calculated, healthcare staff did not recognise that these observations might have indicated significant clinical disease. The observations were not repeated to assess for improvement or deterioration.

74. The clinical reviewer considered that given Mr Boast's low oxygen saturation and rapid pulse, it might have been more appropriate for healthcare staff to observe him closely themselves over a period of time or, if this was not possible, to transfer him to hospital for this observation to continue. We make the following recommendation

    The Head of Healthcare should ensure that healthcare staff know how to respond to lower/abnormal observation results and NEWS2 scores.

Handover information sharing

75. At the end of healthcare hours on 9 August, healthcare staff handed over to prison officers, telling them that they should keep an eye on Mr Boast in case his health deteriorated. No close observation was requested. Prison staff did not receive specific information on how often to observe him, what to look for (such as breathing difficulties), or when to call 111 or 999.

76. Mr Boast's RSA was also asked to keep an eye on Mr Boast. He was happy to do this and did so through the evening of 9 August. There is nothing wrong in asking an RSA, who knows a prisoner well, to keep an eye on him and alert prison staff if he has any concerns, but we consider it would be inappropriate to place responsibility on a RSA to monitor another prisoner's health. It cannot be a substitute for providing prison staff with detailed guidance on what specific signs of deterioration to look out for and what action to take if they have concerns. We recommend:

    The Head of Healthcare should ensure that healthcare staff give prison staff detailed and specific guidance in handovers when a prisoner's health is causing concern, including the required frequency of observations, signs of deterioration to look for, and when to seek advice from 111 or to ring 999.

SystmOne administration

77. The clinical reviewer found that although care plans were created for Mr Boast's chronic medical conditions, they were filed separately as an attachment in the letters section, instead of being filed in the appropriate Care Plan section on SystmOne (Mr Boast's electronic medical record). At interview, the Head of Healthcare said that all healthcare staff knew where the care plans were filed and how to access them, but that they had started a new project to ensure that healthcare staff used the appropriate section in SystmOne in future. We recommend:

    The Head of Healthcare should ensure that care plans for long-term conditions are appropriately stored in the correct section of SystmOne.

Cell bell/personal alarm provision on Dorset Unit

78. Many prisoners on Dorset Unit have health, mobility and social care needs. We were told there are no cell bells in the cubicles on the Dorset Unit. Prisoners who want to gain staff attention would need to go to the unit office to see the staff on duty and ring the doorbell there if they were unable to see staff. We were told that where this was not possible, prisoners called out to each other or banged on the wooden cubicle walls. We were also told by several staff that there were no personal alarms for prisoners on Dorset Unit.

79. In addition to his mobility issues, Mr Boast had complex health needs and his health was known to be deteriorating. The only way for him to get help on the night of 9/10 August was to call out for his RSA or other prisoners, or bang on his wooden cubicle walls. These options might not have been possible for someone who was having or had recently had a heart attack.

80. While the provision of a personal alarm might not have changed the outcome for Mr Boast, it might have allowed him to summon help more easily. Although we recognise that there are costs associated with personal alarms, we do not consider that the current situation is sufficiently safe. We consider that giving personal alarms to those with serious health and/or social care needs would provide a more immediate means for those prisoners to contact staff, especially at night. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that prisoners on Dorset Unit, especially those who are ill or immobile, have a personal and immediate means of alerting staff if they are feeling unwell or need healthcare assistance.

Emergency Response

81. PSI 03/2013, Medical Emergency Response Codes, requires prisons to have a medical emergency response code protocol which should trigger healthcare staff to attend immediately (if they are on duty) and control room staff to call an ambulance immediately. It says that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. It makes it clear that there should be no delay in calling an ambulance (for example, it must not be a requirement for a member of the prison healthcare team or a Duty Manager to attend

the scene before emergency services are called). The PSI also says, “It is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required.”

82. There were delays in calling an ambulance on the morning of 10 August and the emergency response code protocol was not followed. Officer A did not call a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) when he found Mr Boast struggling to breathe in his cubicle.

83. At interview, Officer A said that this was because he did not feel he needed to as there was already another staff member on the unit. CM A told the investigator that codes are not called when healthcare staff are not in the prison. We are concerned that these responses fail to recognise that a key purpose of a medical emergency code is to ensure that an ambulance is called without delay.

84. Officer A called CM A and told him of Mr Boast’s condition. They agreed an ambulance should be called. Officer A rang off to call the Communications Room to direct them to call an ambulance. There was therefore a delay between Mr Boast being found by staff and the communications room being directed to call an ambulance.

85. There was then another delay in the communications room. The OSG recorded the call from staff on Dorset Unit at 6.30am and made her 999 call at 6.35am. This is a gap of up to five minutes.

86. Overall, there was a delay of around ten minutes between Mr Boast being found by prison staff and an ambulance being called.

87. In this case, the clinical reviewer considered that these delays did not contribute to Mr Boast’s death. However, in other cases, a delay of even a few minutes might make a critical difference in a medical emergency. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies in line with Prison Service Instruction (PSI) 03/2013. In particular, where there are serious concerns about the health of a prisoner, staff should use an emergency code immediately to alert control room staff to call an ambulance automatically.

Sharing of PPO reports

88. We consider that it is important for staff who were involved in Mr Boast’s care to see the findings of our investigation. We make the following recommendations:

The Head of Healthcare should share this report with Nurse A and the senior HCA and discuss the Ombudsman’s findings with them.

The Governor should share this report with Officer A, CM A and the OSG who was the Communications Room Operator on the morning of 10 August 2020 and ensure that a senior manager discusses the Ombudsman’s findings with them.

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Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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T I 020 7633 4100