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BY H.M CORONER

National Offender Management Service

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Assistant Coroner Karen Harrold
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[redacted]

Dear Coroner,

RE: the death of Garry Gilbey on 3 July 2012 whilst in HMP Kingston.

Thank you for your letter to Andrew Selous, Minister for Prisons dated 10 December, concerning the inquest into the death of Garry Gilbey, who died at HMP Kingston on 3 July 2012. I am replying as Equality, Rights and Decency Group (ERD) part of National Offender Management Service (NOMS) has ownership of suicide prevention and self-harm management policy in prisons and for sharing learning from deaths in custody.

As you know HMP Kingston is now closed. This response includes the contribution provided from NHS England. I have dealt with the points in the order that you raise them:

Calling ambulances
Since Mr Gilbey's death Prison Service Instruction 2013/03 Emergency Response Codes has been issued. The PSI reminds staff who can call a medical emergency, and provides guidance on the use of the correct medical emergency codes, and what information should be communicated to the control room from the scene of the incident. It also states that all Governors must have a Medical Emergency Response Code protocol in place that is based on the PSI and that all prison staff must be made aware of and understand the instruction and their responsibilities during medical emergencies. I have attached a copy of the PSI for your information.

Training and clarity on medical emergencies for night time prison staff

PSI 24/2011 National Security Framework Nights Function Management and Security of Night State requires that all prisoners must be locked up during the night state and that Local Security Strategies (LSS) must state clearly the procedures staff should follow if faced with a potentially life-threatening situation. Staff must have access to the LSS and be aware of the implications of this for their role in maintaining security during the night state. There are many incidents that may occur at night and it is difficult to be prescriptive about what actions to take in each particular case.

Under normal circumstances, authority to unlock a cell at night must be given by the Night Orderly Officer (NOO). No cell will be opened unless a minimum of two/three (subject to local risk assessment procedures) members of staff are present one of whom should be the NOO. All staff have *a* duty of care to prisoners, to themselves and to other staff and the preservation of life must take precedence over other directions. Where there is, or appears to be, an immediate danger to life, then cells may be unlocked without the authority of the NOO and an individual member of staff may enter the cell on their own. However, night staff should not take action that they feel would put themselves or others in unnecessary danger.

Before entering a cell:

a) Every effort should be made to gain a verbal response from the prisoner.
b) This, together with what the member of staff can observe through the panel and any knowledge of the occupant(s), should inform a rapid dynamic risk assessment of the situation and a decision on whether to enter immediately or wait for assistance.
c) The Communications Room/Control Room must be informed before entering the cell stating the location of the cell and describing the circumstances that require intervention.

Cells should only be entered using the sealed pouches. There must also be clear instructions about the unhindered admission of the emergency services during the night state.

Flagging healthcare events to night staff and healthcare systems for checking that all necessary specialist investigations are fully recorded and carried out as well as results properly checked when they return.

Under the Health and Social Care Act, NHS England has responsibility for commissioning and quality assuring an equivalent health service for prisoners to those who are in the community and as such NHS England believe they have commissioned an equivalent service. Service specifications are reviewed on a regular basis and changed in line with new national guidance from NICE or as a result of lessons learnt from previous deaths in custody or serious untoward events.

All establishments have access to the same level of service that they would receive in the community which is an in-house healthcare service and access to Out of Hours urgent care to an equivalence of the community. As such 24/7 healthcare would not always be provided in-house as this would not be an efficient use of limited resources. Some establishments where there is an in-patient unit will have 24/7 in house healthcare although for the majority of establishments this is not a requirement.

Within the new specifications for prison healthcare services there is a contractual requirement for the management of appointments and referrals including those that Did Not Attend (DNA) having an automatic referral to secondary care services.

There is a requirement that systems must be in place to ensure that patients can attend medical appointments outside the establishment. Appropriateness of referrals must be subject to regular peer review. They must keep and maintain a detailed database which includes the planning of appointments and follow up requirements.

NHS England are happy to work with NOMS to review pathways and protocols both at a national and local level to see if there are further lessons that we can learn as a result of this tragic incident

I hope that you find this response helpful and reassuring.

Yours sincerely,

[redacted]

NOMS Equality, Rights and Decency Group