Investigation into the circumstances surrounding the death of a man at HMP & YOI Exeter in June 2009

Report by the Prisons and Probation Ombudsman for England and Wales

June 2011

This is the report of an investigation into the circumstances surrounding the death of a man in June 2009. The man, who was 40 years old, died after using the gymnasium at HMP and YOI Exeter. His health had apparently been good and his death was sudden. Despite strenuous efforts to revive him, he died from acute myocardial infarction, that is a heart attack.

He arrived at Exeter just two weeks before he died, having been recalled to prison following breach of his licence conditions. He was sentenced to six years imprisonment, with an extended licence period of three years, by a court in 2004. He had been released on parole in March 2008.

I would like to extend my personal condolences to his family and friends for their loss. The loss of a loved one at any time is difficult, but especially so when they are still relatively young, die unexpectedly and are in custody. I am conscious that this investigation report has been delayed and that this will only have added to the family's grief. There were complications in regard to further investigations undertaken by Devon and Cornwall Police into the conduct of some clinical staff. Their investigations were not concluded until 10 May 2010. This inevitably had an impact on the clinical review and also on the timeliness of my own investigation. I apologise for the delay and the additional stress this has caused.

This investigation was carried out by my colleague. A clinical review, for which I am most grateful, was undertaken by a clinical reviewer on behalf of the local PCT. I would also like to thank the Governor of HMP Exeter and his staff for their help and co-operation during this investigation.

I make four recommendations in this report concerning health checks before gym use, training nurses to respond to cardiac emergencies and provision of emergency equipment. I also suggest that the Governor and the local PCT consider the implications of the further recommendations made by the clinical reviewer in his clinical review.

I am happy to report that all the recommendations I made in the previous draft version of my report have been accepted.

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.

Jane Webb
Acting Prisons and Probation Ombudsman **June 2011**

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SUMMARY

The man returned to HMP Exeter on 25 May 2009 following revocation of his licence. He had originally been sentenced to six years imprisonment, with three years extended sentence on licence in 2004. He was released from prison in March 2008. However, when he breached his licence conditions in May 2009, his probation officer ordered that he should be recalled to prison.

When he arrived at Exeter on 25 May, he had an initial health screen assessment which required that he should be seen by the doctor for a prescription of anti-depressant medication. He reported no other health problems. He was seen again on 1 June by a healthcare assistant for a secondary health check, which highlighted no further problems other than his wish to be checked for any blood borne viruses.

He had used a gymnasium extensively in the community. On 9 June, he visited the prison gymnasium as part of his induction process. He completed the routine self-declaration health questionnaire and answered 'No' to all the questions, indicating that he felt fit and well and had no heart or breathing problems. He undertook some cardiovascular exercises, but appears to have tried very hard to compete with a younger prisoner who was using the gymnasium at the time. When he returned to his cell just before lunchtime, he was sick and felt unwell.

He was seen by Nurse A, who suggested that he had exercised too vigorously in the gymnasium. He thought that he would be better after some rest and taking liquids. The nurse left him in his cell with his cell mate. After lunch, which he did not eat, he still felt unwell. He started having chest pains and continued to vomit. His cellmate called for staff assistance. Officer A responded to the call and summoned a nurse to see him.

At approximately 1.15pm Nurse B arrived to assess him. He agreed with the first nurse's opinion that he had probably overdone his workout in the gymnasium and would benefit from more rest. He agreed with the nurses' view, but continued to feel unwell.

His cellmate left the cell at approximately 2.15pm, believing that he had gone to sleep. He returned at approximately 3.30pm and soon realised that he was not breathing as he could not get any response from him. He raised the alarm and staff arrived to help.

Despite the efforts of prison staff and paramedics, he could not be resuscitated and the prison doctor declared that he had died at 4.25pm.

My recommendations concern checking prisoners' health before they use the gymnasium and emergency equipment and training.

THE INVESTIGATION PROCESS

1. This investigation was undertaken by one of the investigators from my office. He first visited Exeter on 9 July 2009 when he was shown around the prison and given access to the man's prison records. He met members of the local branch of the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB). (Each prison has an Independent Monitoring Board. IMB members are independent and unpaid. They monitor day-to-day life in the prison and ensure that proper standards of care and decency are maintained. The IMB produces an annual report on its work.) Neither the IMB nor the POA had anything specific to bring to the investigator's attention at this time, but both said they would help wherever they could, for which I am grateful.

2. Whilst on this visit, the investigator held informal discussions with a number of prison staff who had known the man. He also had access to the cell which the man occupied at the time of his death.

3. Notices to staff and prisoners were displayed by the prison. They invited anybody with information to talk to the investigator. The man's cellmate was the only prisoner the investigator met formally and he was interviewed on 9 July.

4. The local Primary Care Trust (PCT) was asked to undertake a clinical review of the care the man received while in custody. The clinical reviewer carried out this review on their behalf for which I am grateful.

5. A family liaison officer contacted the next of kin to inform her of the investigation and to give her the opportunity to raise any questions or concerns about the care he had received in prison. She requested a visit from the FLO and the investigator and they arranged to meet on 23 July 2009. At that meeting, the man's partner raised a number of issues. They were:

    1. Was a medical assessment done before he was allowed to use the gym?

    2. His clothes had been washed and ironed before they were returned to you and you would have preferred to have retained the smell of him on them.

    3. Why did the two nurses who saw him in his cell not send him to hospital?

    4. Why was he not seen by the prison doctor when he presented with chest pains?

    5. The support received from the chaplain was cut off abruptly when they discovered he had a daughter.

6. Was his daughter given financial assistance to travel to his funeral as she did not attend despite having contact for directions to the cathedral?

6. I hope this report helps to address the concerns the family may have and provides them with a better understanding of the events leading to his death. The part time chaplain at the prison was initially the family liaison officer. She helped the man's partner through the early stages of breaking the news of his death and assisted her over the following few days. It later turned out that he also had a daughter whom the Coroner's office was treating as his next of kin. Notwithstanding that, both the prison and the Coroner's office maintained contact with his partner and his daughter equally. Unfortunately, a few days after the chaplain took on the role of FLO, it was decided that another member of staff should take over in this role. The prison has also informed me that they would not normally pay travel expenses for relatives to attend a funeral as this is usually a matter for social services. His clothes were washed as the prison did not wish to return them in an unwashed condition. I would remind the prison of the guidance in PSO 2710 section 4.25.

7. Devon and Cornwall police investigated whether there were grounds for a criminal case of gross negligence, manslaughter to be laid before the Crown Prosecution Service (CPS) in the matter of his death. They were particularly concerned about the actions of nursing staff in the early assessment of his presentation of chest pain. As a consequence of their enquiries, my own investigation had to be suspended until the CPS had decided whether to proceed with any prosecution. I was informed on 10 May 2010 that the CPS considered there was not sufficient evidence to prosecute anyone for gross negligence manslaughter in this instance. I therefore resumed my investigation from that date.

HMP & YOI EXETER

8. HMP Exeter was built around 1850. It is a local category B prison serving the courts of Cornwall, Devon and West Somerset. This means it holds adult male prisoners and young offenders, both on remand and convicted from the local area. It has a maximum capacity of 533 prisoners.

9. The report of the prison's Independent Monitoring Board covering the period from November 2008 to October 2009 commends the good practice in the Health Care Unit. This report also highlights good work undertaken by PE staff: 'We find the PE team strongly motivated and inspirational.'

10. The most recent inspection by HM Chief Inspector of Prisons was an announced full inspection carried out from 12 - 16 October 2009. Her subsequent report noted that health services were "generally good".

11. The prison has a sports hall and weights room with multi-gym. The Physical Education (PE) programme is run throughout the week with some evening provision. All activities are supervised by PE Officers (PEOs) and include circuit training, cardio vascular training, volleyball, badminton, weights and football. All users of the gymnasium must first complete an induction programme which includes a self declaration of health problems using form PAR-Q (Physical Activity Readiness Questionnaire). Prisoners using the gymnasium also have to complete and agree to abide by the PE compact which sets out the rules for use of the gymnasium.

12. Healthcare services at Exeter are delivered by a complex group of healthcare providers including three mental health trusts, the local Primary Care Trust and the prison itself. There is a large purpose built healthcare centre which has room for 21 in-patients, a day care facility for people with mental health problems who normally live on prison wings, and a number of consulting rooms for visiting doctors. Each wing has its own primary care facility which includes a GP consulting and medicine dispensing area (an area where patients can be seen by the doctor and have medicines issued to them).

13. Since the Ombudsman assumed responsibility for investigating all deaths in prisons in 2004, I have investigated 12 previous deaths at Exeter. Of these, five were the result of natural causes. Of particular relevance to the current investigation is the death of a prisoner in February 2005. As a result of that investigation I made recommendations relating to the availability of emergency equipment within Exeter. This is a concern that I return to in this report, although the circumstances that occurred in this instance, are unlikely to have made a difference to the outcome for the man.

KEY FINDINGS

14. The man was released from HMP Whatton on 20 March 2008. He was serving a six year prison sentence with a three year extended licence, to be served in the community. This was the result of a sentence imposed on 9 July 2004 at Crown Court for serious sexual offences. It meant that he would serve time in prison and then had to abide by his licence conditions once he was released from prison until his licence expiry date (which had been calculated as 21 September 2011). Unfortunately, it appears from the Probation Service records, that he started drinking, committed an offence and was judged by his probation officer to be at increased risk of further offending. He was therefore recalled to prison on 22 May 2009. He was received at Exeter on 25 May.

15. When he arrived at Exeter, he did not wish to receive the usual induction talks as he felt he knew what to expect in prison, having only recently been released. He did, however, see the healthcare team to whom he revealed a history of depression since February 2009. He had been prescribed Fluoxetine, an anti-depressant medicine, by his GP. This was continued once he arrived in prison and he was referred to the community psychiatric nurse (CPN) for ongoing support. He also began nicotine replacement therapy as part of a smoking cessation package.

16. He was seen for a secondary health screening on 1 June, by a Healthcare Assistant (HCA). His only additional observation to the initial health screening was that he should have blood borne virus screening and vaccination if appropriate. He did not report any ill health or history of heart disease, although it does not appear from the clinical record that any attempt was made to verify this with his GP.

17. On 9 June, he went to the gymnasium for the first time since his return to prison. This was an induction visit, and he therefore had to complete a PE compact and a PAR-Q form. He declared on those forms that he was willing to abide by the rules, including warm up and cool down exercises and that he had no medical problems.

18. When he returned to his cell, he did not speak to his cell mate immediately, but got a drink and started to eat an orange. Almost immediately he was sick on the floor, having been unable to reach the toilet in the cell. His cellmate asked if he was alright, and he replied ‘No, I am feeling rough’. He asked if there was anything he could do, but he declined any help at that time.

19. Shortly afterwards, he made his way to the toilet, lay on the floor and vomited again. He told his cellmate that he felt light headed and sick. It was about this time that their cell was unlocked so that they could go for lunch. His cellmate said in interview that he collected his own meal, but the man said he did not want any food. When his cellmate returned to the cell, the man had attempted to clean the floor.

20. The cellmate went to get a mop to clean more completely than he had been able to do. When collecting the mop, he spoke to two officers. He told them that the man was being sick and was unwell. Officer B went to check on his welfare. After visiting his cell, he asked the senior officer in charge of the wing to arrange for a nurse to see him.

21. Nurse A arrived at the man's cell at approximately 12.45pm. He saw that he was sweating, had some stomach discomfort and was 'feeling a bit wobbly'. He told the nurse that he had last been to a gymnasium approximately 15 months before and he felt he had probably just overdone it.

22. The nurse asked him if he had eaten or drunk very much either at the gym or since returning. He said he had not had much. The nurse told the investigator that he thought that his condition was due to dehydration and/or overdoing the vigorous exercise. He suggested that he should rest and take fluids. He advised him that, if he felt no better shortly, he should ring his cell call bell and ask for staff help.

23. His cellmate recalled in interview that, after the nurse left their cell, the man was sick again about 20 minutes later and said he still felt rough. He climbed up onto his bunk bed and tried to rest. However, a short time later, he asked him to call for staff assistance as he was experiencing chest pain, which he described as a pinching sensation in his chest.

24. Officer A arrived at their cell door in response to the cellmate's call at about 1.05pm and asked what the problem was. First he and then the man explained that he felt unwell and now had chest pains. The officer told them that she would arrange for a nurse to attend. She called by telephone for someone from healthcare to go and see him. Nurse B arrived at approximately 1.15pm.

25. The man reported that he was feeling a lot better. He explained that he had been to the gymnasium for the first time in a long time and he thought he had overdone it that morning. The nurse took his blood pressure reading (117/82, which is normal) and his pulse rate, which was 64 beats per minute (also normal). In interview with the investigator, Officer A recalled that he told her and Nurse B that he had used various pieces of gym equipment during the morning. He explained that he had spent some time on a rowing machine in competition with a young prisoner. He said that he had been trying to keep up with this younger prisoner and that he had overdone the exercise.

26. Nurse B spent approximately 15 minutes with him and gained the same impression as Nurse A, especially as he seemed much better and gave him no cause for concern.

27. Sometime after the nurse left, he made himself a cup of coffee. He was sick again after drinking some of the coffee and then returned to his bed. He seemed to his cellmate to settle down and go to sleep.

28. At approximately 2.15pm the cellmate left the cell, believing that the man was asleep, and went to a tutorial with a member of the education department.

29. He returned to his cell about 3.30pm and did not realise immediately that anything was amiss. After a short time, he began to suspect that the man was not breathing. He had not heard him snoring which he usually did when asleep. He tried to rouse him, first by calling to him, then by gently shaking and calling to him. Finally he said that he tried to 'feel' if he was breathing by placing his hand between his nose and mouth.

30. When he realised that he was not responding, he called for staff assistance. Officer D answered his call for help. When he went into the cell and was unable to get any response, he went onto the landing and saw Officer C on the landing below (B3 landing). The officer asked him to call for the SO to attend to a 'code blue' call. (Code blue is an emergency code used to indicate that a person is having breathing difficulties and needs urgent medical assistance.)

31. It is not clear exactly who made the radio call to the communications centre, but the message that there was a code blue emergency on B4 landing was transmitted at approximately 3.45pm. Staff in the immediate area, including the SO and three officers, went up to B4 landing. Nurse C was on B3 landing at the time and she also made her way to B4.

32. When Nurse C entered the cell, she checked him for any signs of life. She could not find any pulse or signs that he was breathing. He was cold and clammy to the touch. Staff moved him to the floor and she and Officer E began cardio pulmonary resuscitation (CPR). Meanwhile, Officer C accompanied the cellmate to an office away from the cell.

33. Nurse C gave instructions for an ambulance to be called and for someone to fetch the emergency kit containing the defibrillation machine. Nurse D went to get the defibrillation machine and met Nurse E on the way. (An Automatic External Defibrillation machine (AED) is a sophisticated, reliable, safe, computerised device that delivers an electrical shock to a person in cardiac arrest. It gives voice and visual instructions to guide the person using the machine, and is suitable for use by lay people and healthcare professionals. AEDs analyse the person's heart rhythm, determine the need for a shock, and then deliver a shock. A semiautomatic AED advises the need for a shock, but this has to be delivered by the operator when prompted.) They returned to the cell with the defibrillator. Nurse C, Officer E and F (who had also arrived by this time), performed CPR in rotation in an effort to revive him.

34. When the defibrillation machine arrived, Nurse C, assisted by Nurse E and Nurse B, applied the shock pads to his chest. The staff stopped CPR and allowed the machine to analyse whether a shock could be given. The machine could not find a shockable rhythm and therefore instructed that CPR should resume. This process was repeated at least once more before the first paramedic team arrived with their equipment.

35. The paramedic team also attached their defibrillation equipment to him and the instruction was repeated that staff should continue CPR. A second ambulance arrived, but despite the efforts of everyone there, he could not be resuscitated.

36. The prison doctor was called to the cell, but when he arrived all that remained for him to do was to certify that the man had died, which he did at 4.25pm. The post mortem confirmed that he had died as a result of severe narrowing of his coronary artery which was completely blocked by a thrombosis (a blood clot), which stopped his heart working.

ISSUES

Using the gymnasium

37. When a prisoner first arrives at a prison, they undergo an induction process. This ensures they are given information about the prison and ascertains if there are things that need doing for them (either as part of their healthcare needs or their offence management). Part of this process will usually include an induction for the use of the gymnasium, should they wish to use that facility. After prisoners have applied to join the gym, they are normally collected by staff for an induction and assessment session. Every prisoner who applies is entitled to be assessed. The induction process involves a one to one interview with a PEO, during which the prisoner is introduced to the equipment and shown how to lift weights safely. The rules are explained and a Physical Activity Readiness Questionnaire (PAR-Q) is completed, as per Prison Service Order (PSO) 4250. Prisoners are asked about their medical history and if they are taking any medication. The PSO states:

> 'All prisoners may participate in PE activities. Prisoners will not be restricted unless otherwise authorised by the Governor and/or a Healthcare professional. All PE departments must deliver a comprehensive induction programme, which must include as a minimum requirement:
>
> 'Explanation of PE rules and regulations …
>
> 'Instruction on basic weight training, safe use of PE equipment and machinery …
>
> 'A Physical Activity Readiness Questionnaire (PAR-Q) must be completed for all prisoners on PE induction prior to participating in PE activity and signed by both the prisoner and a member of PE staff …
>
> Elements of first aid, safe handling and lifting.'

38. PSO 4250 stresses the importance of the induction process into the gymnasium. It says the induction should include a demonstration of the safe and proper use of each piece of equipment. The PSO also stresses the importance of doing warming up and cooling down exercises. The induction should also cover the action to be taken if an injury occurs or if someone feels unwell after using the gym.

39. The PAR-Q is a self declaration of any health problems the prisoner might have and should be checked by PE staff before anyone uses the gymnasium. It does not say specifically that the PE department should check the validity and accuracy of what has been written with the healthcare department.

40. The PE department did not validate the man's PAR-Q form before he was allowed to use the exercise equipment. If they had checked with healthcare, they would not have discovered anything more than he had declared on his

form, except that he was taking medication for depression. (As I have said, his only health concern on his initial health screen on 25 May was that he suffered from depression, for which he was taking Fluoxetine 20mgs a day.)

41. When he was assessed by a prison doctor later on 25 May, the doctor recorded that his health was generally good, that his blood pressure was 132/92 (which is very slightly raised, but would not have triggered any follow up normally) and that there was no family history of any concern. He prescribed Fluoxetine 20mgs once a day.

42. His secondary health screen, or Well Man Assessment, was completed on 1 June by a Healthcare Assistant (HCA). She noted that he wanted to be screened for blood borne viruses and made a referral for that to happen. She also made a note that his familial health history was not known because he was fostered. The HCA recorded his blood pressure and pulse. The results showed a normal blood pressure (137/86) and a normal pulse (73 beats per minute). Apart from the information that he smoked only one cigarette a day and was a moderate drinker, there was nothing else of any note recorded by her assessment.

43. However, I judge that the PAR-Q procedure at Exeter should be revised to take account of prisoners who either have declared health problems, or those who fail to disclose their full medical history accurately. It would be good practice for the PE department to verify the prisoners' information with the healthcare department before they are allowed to use the gymnasium.

The Governor, in conjunction with the Healthcare Manager, should revise the system for assessing prisoners' fitness to use the gymnasium and ensure that full health checks are completed and verified before prisoners are allowed to use the gymnasium.

44. Despite my recommendation, I stress that failing to verify his medical history prior to his use of the gymnasium, did not contribute to his death.

Clinical issues

45. The main issue arising from his death is the need for healthcare staff to assess cardiac problems competently. The clinical reviewer makes the point that both the healthcare staff who initially assessed him were registered mental health nurses (RMN), who had not received recent training in recognising acute cardiac problems. It does not necessarily follow that RMNs would fail to recognise the signs of a cardiac arrest, but without regular training in that specialist field, it is less likely that they will have the knowledge and skills to safeguard patients.

46. In this instance, both Nurses A and B assessed him in the hours before his final heart attack and judged that he was suffering from over exertion in the gymnasium. They missed the signs that the clinical reviewer says were present and indicated that he might have been having a cardiac arrest when they visited him in his cell.

47. The clinical reviewer says:

> 'I feel that the man complained of certain symptoms that could suggest he had suffered a cardiac event (such as a heart attack). These symptoms were not acted upon by the nurses who attended him. While this might not have altered the outcome early detection and intervention in acute cardiac incidents is critical to improving survival rates.'

His recommendation, with which I concur, is that all nursing staff (whatever their specialism) should be trained to recognise the signs of acute cardiac events.

The Primary Care Trust should ensure that all nursing staff at HMP Exeter are competent in triage and in particular the recognition and immediate treatment of patients suffering from acute cardiac events.

The Healthcare Manager should develop a formal training programme for all nursing staff and keep a record of who has received what type of training. This should be updated on an annual basis for each member of the clinical staff and discussed at their annual appraisal with their learning needs recorded and tracked via their Personal Development Plans.

Response to the emergency

48. The investigator viewed the CCTV footage during the incident involving the man (the CCTV showed images of the landing his cell was on looking towards his cell). There was some small delay in staff attempting CPR when he was initially found at approximately 3.45pm. The first member of staff to attend the cell when the cellmate raised the alarm was Officer D. Having gone into the cell and found that he did not respond to calling and shaking him, the officer left the cell to summon other staff assistance. He attracted the attention of Officer C and asked him to get the SO to attend immediately. It was not until Officer E reached the cell after hearing the 'code blue' emergency call over the radio, that anyone started to perform CPR. This only took about two minutes, but it is evident from the digital images that there seems to be hesitation on the part of staff to start CPR. This might indicate either a lack of training or a lack of confidence by the staff who were first on the scene.

49. The investigator has examined the first aid training records at Exeter. Of the 213 uniformed staff working there, 32 were First Aid qualified at the time of the man's death including ten senior or principal officers, seven who worked in the healthcare unit and 15 officers including Officer E. There appears to be another additional group of 52 staff who are trained as 'First on scene and First Aid' to provide an immediate response to an emergency until a more experienced and qualified individual arrives to take over. The training manager at Exeter told the investigator that these staff had been on an internal training course and received basic life support, including CPR

training. She told him that there are plans to increase the number of first aid qualified staff.

50. There is a balance to be had in the number of staff trained in First Aid within the prison's staffing complement and the number expected to be on duty at any one time. This can be particularly difficult to manage at times of low numbers on duty, for example at night time. I make no formal recommendation as regards numbers of first aid qualified staff at Exeter, but would urge the Governor to fulfil his intention to train further uniformed staff in first aid and CPR.

51. The clinical reviewer also comments on the number and placement of defibrillators and resuscitation bags in the prison. At the time that he wrote his clinical review there was only one defibrillator and resuscitation bag which was kept in the healthcare unit. In the circumstances surrounding the man's death, there was some delay before the emergency equipment was taken to his cell. His recommendation, with which I also concur, is that:

The Governor should install more defibrillators and emergency resuscitation bags around the prison. All staff, including prison officers, should know where the defibrillators are kept and be prepared to take them to the site of an incident.

CONCLUSION

52. The man arrived at Exeter on 25 May 2009. Within the next fortnight he went to the gymnasium for his induction. He went on to use the exercise equipment and, after returning to his cell, felt unwell. He was assessed soon afterwards by two nurses, both with mental rather than general nursing qualifications, who concluded that he had exercised too vigorously earlier that day. They advised him to rest and neither considered that further medical attention was necessary.

53. In the middle of the afternoon his cell mate discovered that he might not be breathing. He called for staff assistance. Staff tried to revive him but, despite their efforts and those of paramedics, he was declared dead at 4.25pm.

54. His death is one of 16 deaths that have occurred in English prisons following use of the gymnasium in the period between May 2005 and the end of 2009. I am satisfied that there are no other common factors and, with the National Offender Management Service and Offender Health, have considered the learning from the events.

55. In this case I consider that the decision to permit him to use the gymnasium at Exeter was reasonable. He declared there was nothing medically wrong with him and he was keen to use the gymnasium. I am satisfied that the proper checks and process for gym induction were followed. Even if the prison were to have followed my suggested additional safeguard of validating PAR-Q forms, it is unlikely that any restrictions would have been imposed on his use of the gymnasium.

56. The clinical reviewer highlights the fact that the nurses who saw him on the afternoon of 9 June were inadequately trained for the task they were required to undertake. He says the man's signs and symptoms were not recognised or acted upon by the nurses who attended him. They told my investigator that they believed he was suffering fatigue and dehydration from over exertion in the gymnasium.

57. He had most certainly exerted himself in the gym. Had the signs been recognised early enough, the correct course of action would have been to refer him as an emergency to the local hospital, where tests might well have revealed he was having a heart attack. The clinical reviewer says 'early detection and intervention in acute cardiac incidents is critical to improving survival rates'.

58. Although there is no guarantee that he would have survived, the clinical reviewer is concerned that staff at Exeter need training in recognising acute cardiac events and triaging. I endorse the recommendations he makes about these important matters.

RECOMMENDATIONS

1. The Governor, in conjunction with the Healthcare Manager, should revise the system for assessing prisoners' fitness to use the gymnasium and ensure that full health checks are completed and verified before prisoners are allowed to use the gymnasium.

   Service response: Recommendation accepted and action completed and fully implemented. A system whereby prisoners attend the gym for induction programme and complete a questionnaire stating that they have no medical condition that would deem their attendance at gym sessions detrimental to their health. If any concerns are identified through this process they are requested to see the doctor who can make a medical assessment and decide if they are fit for gym or not, or for remedial gym.

2. The Primary Care Trust should ensure that all nursing staff at HMP Exeter are competent in triage and in particular the recognition and immediate treatment of patients suffering from acute cardiac events.

   Service response: Recommendation accepted and action completed and fully implemented. Training is ongoing as a rolling programme. All Nurses employed by Devon Partnership Trust of Newcross agency have to have first Aid course which in the course contents covers emergency treatment of individuals suffering a potential heart attack. Records of training will be held in individual staffs personal records. In addition to First Aid course several members of staff have completed the minor injuries/illness course facilitated by Plymouth University and it is hoped that eventually all staff will be able to attend these 6 day sessions that are organised annually.

3. The Healthcare Manager should develop a formal training programme for all nursing staff and keep a record of who has received what type of training. This should be updated on an annual basis for each member of the clinical staff and discussed at their annual appraisal with their learning needs recorded and tracked via their Personal Development Plans.

   Service response: Recommendation accepted and action completed and implemented. A copy of all staff training should be held in the personal files of staff. Devon Partnership Trust has e-learning packages and staff completion of mandatory training is checked weekly. Health care staff have monthly supervision sessions and their mandatory training is checked at this time to ensure that it is in date.

4. The Governor should install more defibrillators and emergency resuscitation bags around the prison. All staff, including prison officers, should know where the defibrillators are kept and be prepared to take them to the site of an incident.

   Service response: Recommendation accepted and completed. Defibrillators are located in the centre of the prison, the healthcare treatment room and on D wing officers landing level 2.