

**INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE
DEATH OF A MAN AT HMP WAYLAND IN AUGUST 2007**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

May 2008

This is the report of an investigation into the death of a man in August 2007 in HMP Wayland. The man was 56 years old and died of natural causes.

I offer the family my sincere condolences on their loss and apologise for the delay in issuing this report.

This investigation was undertaken by one of my colleagues. Both he and I would like to thank the Governor and staff of Wayland for their participation. A medical practitioner was identified by Norfolk Primary Care Trust to undertake a review of the man's clinical care and she was assisted in doing so by another officer. I also appreciate their assistance.

Indeed, in a case such as this, where someone has died from natural causes, the findings of the clinical review play a large part in my report. In this case, the reviewers find that he generally received a good standard of care whilst in prison.

I conducted another investigation into a death at Wayland some months before this man's death and made a number of recommendations on my subsequent report. Some of the concerns uncovered in this investigation were the same as I had identified previously. The Prison Service did not have the benefit of seeing my previous report before the man died, but later accepted the recommendations I made. I therefore only make two recommendations to the Governor in this report. However, I draw his attention to the issues common to both investigations so he can assure himself that they have indeed been addressed.

I understand that the man who died was noted for his commitment to health and fitness. He was often described as a 'fitness fanatic'. It is particularly sad that he should have died of a heart attack immediately after exercising, something that he particularly enjoyed.

This report has been anonymised for publication on my website.

Stephen Shaw CBE
Prisons and Probation Ombudsman

May 2008

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SUMMARY

The man who died was a 56 year old man who was serving a life sentence. He had been released on licence in 2001 but recalled to prison after being arrested for a further offence in the summer of 2002.

On recall, he was taken first to HMP Woodhill but transferred to HMP Wayland in September 2002. He seemed to settle well there and it was continually noted in his records that he was hard-working, polite and respectful. He had a good attitude on the wing and good relationships with staff and other prisoners alike.

The man suffered from angina and prison healthcare services were aware of his condition. His blood pressure was frequently monitored and blood tests were carried out. In November 2005, he complained of chest pain that was not relieved by taking his medication. His heart was checked and he was admitted to hospital for treatment.

The man had a strong interest in health and fitness and was a gym orderly. He was widely regarded as being a 'fitness fanatic' and was often found to be exercising. It was after exercising on the morning of his death that he collapsed while returning to his cell and stopped breathing. Staff tried to resuscitate him and were briefly successful. However, the man stopped breathing again and despite continued staff efforts and the attendance of paramedics, he passed away.

The man's sister, who was his listed next of kin, told my investigator how helpful the prison staff were after her brother's death. She was also moved by the memorial service they held, which she was invited to attend.

THE INVESTIGATION PROCESS

1. My investigator visited Wayland and spoke to staff who worked with the man during his imprisonment. He interviewed seven members of staff and one prisoner. These interviews were conducted with one or both of the clinical review team present. Transcripts were sent to the interviewees, who signed and confirmed their content.
2. Notices were posted to staff and prisoners about the investigation, inviting any contributions. None were received.
3. The investigator studied all relevant prison records relating to the man who died. These included his main prison record, medical records and statements made by staff. The investigator also visited the wing where the man was housed and the wing where he died.
4. The Norfolk Primary Care Trust (PCT) identified a medical practitioner to carry out a review of the man's clinical care. She was assisted by another colleague. I am grateful to both of them for undertaking this review.
5. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Having seen a draft copy of my report, the Coroner decided to proceed with the inquest. My investigator attended and gave evidence. The jury returned a verdict of death by natural causes.
6. One of my family liaison officers spoke to the man's sister, who raised some concerns she wanted our investigation to consider. These are addressed in this report, which I hope also answers any further questions she may have. She made a point of saying that she was grateful for how helpful staff at Wayland had been. She had been moved by the memorial service held in Wayland for her brother, to which she had been invited.
7. My investigator discussed aspects of the man's treatment with both healthcare staff at Wayland and the clinical reviewers. He also attended the panel that the Norfolk PCT held to discuss the clinical review.

HMP WAYLAND

8. Wayland is a category C adult male training prison with an operational capacity (maximum crowded capacity) of 709. It opened in 1985 and since then the buildings have been extended three times. It now comprises eight residential units, mainly with single cell accommodation.

Healthcare

9. Healthcare at Wayland is available from 8.00am to 8.30pm Tuesdays to Fridays. Saturday to Monday cover is from 8.00am to 5.30pm. A visiting doctor attends on Monday mornings, Wednesday afternoons and Friday afternoons. If a doctor is required outside of these hours, the on-call service is used.

E and F wings

10. E and F wings are adjacent to each other. The door out to the exercise yard is at the end of E wing furthest away from F wing. To move between the exercise yard and their own wing, F wing prisoners are therefore required to pass through E wing. Furthermore, lunch is served in E wing, so F wing prisoners pass between the two to collect their meals. Although the doors in and out of the wings are supervised, there is obviously an element of freedom of movement between the two wings and the exercise yard at certain times.
11. The man's cell was at the end of F wing nearest to E wing. It was his habit to exercise and either to bring his plate and cutlery with him, or pass through E wing to get back to his cell, quickly collect his plate and cutlery, and hurry back through to E wing to collect his meal.

Previous deaths at Wayland

12. This is only the third death in Wayland that my office has investigated since I became responsible for investigating all deaths in custody in April 2004. In the two previous reports I made a number of recommendations, including ones about medical record-keeping, support for healthcare staff involved in a death in custody, inclusion of healthcare staff in hot debriefs (debriefs for staff on the actual day that they have had to deal with a death), and the guidance for breaking the news of a death to a prisoner's family. However, the recommendations that are relevant to the man's death were contained in a report published in December 2007 so the prison would not have had the opportunity to read them before this man died.

Her Majesty's Inspectorate of Prisons

13. The most recent inspection of Wayland by HM Chief Inspector of Prisons was an announced inspection in June 2006. Her subsequent report did not identify any issues particularly pertinent to this investigation.

Independent Monitoring Board (IMB)

14. The most recent IMB report covers the period June 2006 to May 2007. It does not contain any issues relevant here.

KEY FINDINGS

15. The man was sentenced to life imprisonment in December 1980. He moved through the prison system until he was released on life licence in October 2001. In early 2002, the man lost three close family members. His son, his sister and his nephew all died within a few weeks of each other.
16. On 1 June 2002, the man was arrested following an incident that had occurred after he had been drinking. His licence was revoked and he was recalled to prison to continue serving his life sentence. He arrived at HMP Woodhill on 3 June. He was subsequently sentenced to an additional two months' imprisonment for the offence for which he had been arrested.
17. The man remained in Woodhill for approximately three months. His health screening on reception identified that he was deaf in one ear and that he had angina. Staff seemed to keep this under consideration when dealing with him. There is a note on his file from the physical education department that he should be assessed for remedial gym due to his history of angina. There is a further note from the medical officer to the kitchen requesting that the man receive a low fat diet.
18. The man was transferred to Wayland on 10 September 2002 and allocated to E wing. His reception screening noted his angina and that he had an outstanding appointment for a cardiac clinic from before his recall. He signed the compact agreeing to abide by the rules about holding his own medication.
19. Towards the end of that month, the man asked to see the doctor, saying that he was using his GTN spray (used to relieve the symptoms of angina) more frequently and that his blood pressure was slightly raised. His file contains a handwritten note indicating that he was due to be seen two days later, but there is no note of this consultation having occurred.
20. The man was moved to F wing on 24 December. The following May, he was placed on a disciplinary report for being in possession of a stereo that was not on his property card. In the light of this adjudication, he subsequently refused a lifer day out of the prison saying he wanted to complete an offending behaviour course instead.
21. Still in May 2003, when requesting some medication for hayfever, he again mentioned that he had been using his GTN spray more frequently than usual. It is unclear whether any action was taken in response to this comment.
22. In October, the man once more asked to see the doctor, saying that he was suffering from severe chest pain. There is a note on his file giving a date, but once again it is not clear whether the note referred to a consultation, if the consultation occurred and, if so, what happened.
23. Later that month the man lost a tooth filling and asked to see the dentist. There is no note on his file as to whether he had an appointment and in March 2004 there was another request to see the dentist for a lost filling. Again there is no

indication on file as to what happened and in early June yet another similar request was recorded. In March 2005, he made another request to see the dentist for a missing filling and his record shows that on this occasion he was treated for a dental abscess.

24. The man's medical record indicates that in May 2005 he had had an angiogram six months previously, although there is nothing in the chronological notes to show this. The recommendation was that he should continue to be observed and monitored.
25. The Parole Board considered his case and reported that May. They recommended that the man should remain in closed conditions to develop insight into risk situations and coping with difficult emotional upsets. They also said that he needed to undertake additional work on cognitive skills and drug and alcohol relapse prevention.
26. In November 2005, the man complained of chest pain during exercise. He was referred to the Emergency Assessment Unit Medical (where a doctor may refer a patient instead of them going to a hospital accident and emergency department). He was again given an angiogram and prison healthcare staff contacted the hospital before his return to Wayland to clarify whether any further specific needs had been identified.
27. The man was due to attend a cardiology clinic as an outpatient on 7 February 2006. However, he was concerned about the possibility of being readmitted to hospital and refused to attend. Healthcare staff contacted the hospital to arrange a further appointment.
28. The man had been prescribed statin to help his cholesterol level. However it was discontinued in July due to concerns over the effect it might have on his wider health. His cholesterol level continued to be measured on a regular basis. The clinical reviewers judge that discontinuing the medication was appropriate.
29. An escorted town visit was arranged for him on 12 September 2006, and no problems were reported. That same month a mandatory lifer panel of the Parole Board adjourned consideration of the man's case, requesting psychology and medical reports.
30. On 15 December, the man complained of chest pain at 2.00am. It disappeared after he used his GTN spray. The pain returned in the morning, but went away after the man went for a walk. On 20 December, he was given an electrocardiogram (ECG, an electrical recording of the heart used in the investigation of heart disease). He was seen again on 22 December and his blood pressure was checked.
31. The adjourned mandatory lifer panel of the Parole Board met again on 12 March 2007. However, the reports previously requested had not been carried out. His case was once again adjourned to 4 July. Although not relevant to the

man's death, I would draw the Governor's attention to this delay, which strikes me as unacceptable.

31 August

32. On the morning of 31 August 2007, the man had been running in the exercise yard. After exercising he walked through E wing and, shortly before midday, was waiting in the corridor for the door allowing prisoners back into F wing to be unlocked. One of the cells by this door was occupied by prisoner A with whom the man was acquainted. Prisoner A was watching athletics on television and the man stood in the doorway and the two chatted about sport. As he paced up and down, the man was moving and stretching his left arm. Prisoner A thought that he might be suffering from cramp as he had just been exercising. He walked away, prisoner A began to eat his lunch but heard a sudden heavy noise. He put his food down, went to his door and saw the man slumped in the corner of the corridor.
33. Prisoner A went to the man and lifted him up. The man was very rigid, shaking, and sweating profusely. Prisoner A called the man's name, but he did not respond. He shouted for help.
34. A prison officer was on E wing at that time, having been supervising the exercise yard. He remembers seeing the man come back in from his customary run, and that there had been nothing unusual in his appearance or demeanour at that time. On hearing prisoner A's shout for help, the officer went across and was the first to arrive where the man had collapsed. He asked prisoner A to stand aside while he also tried to get a verbal response from the man. Within another minute, the wing senior officer (SO) and a second prison officer arrived. Realising the seriousness of the situation, the second prison officer radioed through to the Communications Centre a Code Blue call for urgent medical assistance. (Code Blue indicates that a prisoner is either not breathing or has seriously restricted breathing.) At this point at least one of the officers also asked Communications to ensure that an ambulance was summoned. The time was now 11.56am. Prisoner A was asked to return to his cell as prisoners were being locked up to allow staff to concentrate on the man.
35. An agency nurse working in Wayland at that time and a pharmacy assistant, were on E wing distributing medication. As soon as they heard the call for help, the nurse ran to where the man had collapsed. The pharmacy assistant collected the emergency grab bag, locked the treatment room and followed. They both reached the man within three minutes of him collapsing.
36. At this point the man was breathing but not responding. The agency nurse and the pharmacy assistant put the man into the recovery position. However, despite this, he stopped breathing. The nurse and the pharmacy assistant immediately began to perform cardio-pulmonary resuscitation (CPR) and after four or five minutes the man began to breathe. However, he very quickly stopped breathing once more. Staff continued to perform CPR, and Communications were asked to update the Ambulance Service accordingly.

37. A staff nurse was working in the healthcare centre when she heard the Code Blue call over the radio. She contacted Communications and told them that there were medical staff, including a nurse, on E wing at the time. She asked if her attendance was also necessary. However, when she did not receive a response within a minute she decided to take the emergency grab bag and go to E wing. While she was on her way across, Communications responded to her earlier question and advised that she should attend.
38. The staff nurse's emergency grab bag differed from the one the pharmacy assistant had taken from the treatment room. Previously, 'live active bags' had been located on wings in the prison. However, maintenance had proved to be a problem - for example, the oxygen cylinders would deplete. Defibrillators (machines that apply electrical impulses to the heart) had previously been available on the wings, but there had been problems with maintenance and they had been withdrawn. As a result, a decision had been taken that all emergency equipment would be supplied from the healthcare centre.
39. The staff nurse arrived on E wing and the pharmacy assistant briefed her as to what had happened. The staff nurse confirmed that an ambulance had been called. There were no defibrillator machines on E wing. The only defibrillator available was in healthcare. The staff nurse asked one of the officers in attendance to go to healthcare and collect it. The staff nurse, the agency nurse and the pharmacy assistant continued to perform CPR on the man.
40. A Principal Officer (PO) was the orderly officer that day and therefore responsible, with the duty governor, for the operational running of the prison. On hearing the Code Blue call, he quickly made his way to E wing, arriving at 12.00 noon. The PO took control of the staff responses and deployment, and satisfied himself that all necessary actions had been undertaken. He ensured that updates were fed back to Communications for onward transmission to the Ambulance Service. The staff nurse asked him to ensure that passage was clear for ambulance/paramedic staff to get through prison security and to E wing as quickly as possible. At some point, the agency nurse went back to the healthcare centre and collected the man's notes in case the paramedic team needed them.
41. When emergency calls are received by the Ambulance Service, staff dealing with the call may despatch a First Response Paramedic who will be able to reach an emergency scene more quickly than an ambulance crew. The Ambulance Service had done so on this occasion, and at 12.17pm a paramedic from the First Response Unit arrived on E wing. He administered adrenaline to the man. The officer sent to collect a defibrillator from the healthcare centre had not yet returned, but the paramedic had brought one with him and applied it to the man. At this point the pharmacy assistant left the area and the first prison officer was replaced by a third prison officer.
42. At approximately 12.26pm, the ambulance crew arrived on the wing and began to try to resuscitate the man. Unfortunately, despite the medical assistance already provided by a number of people, they were unable to revive him. At 12.34pm it was agreed by those present that the man had died. The area was

sealed off until the police arrived at 1.35pm and gave permission for the man to be moved. He was taken from the wing into a healthcare room, where the chaplain arrived and prayed over his body.

43. As the man had collapsed outside his cell, prisoner A had been able to hear everything that happened. By the time the man's body was moved he had become quite upset. An officer remained outside his cell to provide support, and they spoke together. Prisoner A had been trying to give up smoking, but asked the officer if he could get him a cigarette. The prisoner in the cell next door was a smoker and provided a few cigarettes. Later on a Listener came to see him. (Listeners are fellow prisoners who have been trained by The Samaritans to provide support.) Prisoner A asked medical staff if he could have medication to help him sleep. They did not provide anything the first night, but on the subsequent two nights they did provide a sleeping tablet. Healthcare staff who had been involved in trying to resuscitate the man later spoke with prisoner A and reassured him that he did the best he could have done. Prisoner A told my investigator that he was not offered any further counselling or support beyond this.
44. Other prisoners on the wing remained locked in their cells. Staff arranged for a letter to be distributed to prisoners explaining why they had been locked in their cells. They were also informed of various methods of support available. Staff also reassessed any prisoners who were thought to be at risk of self-harm.
45. The pharmacy assistant had become upset by the man's collapse, and was supported by a member of the prison's care team at the time. Once she returned to the healthcare centre, further visits were made to ensure that she had recovered. She was also given telephone numbers for use over the weekend if she felt she needed them. The staff nurse commented that there was some support for healthcare staff, but that it might not have been adequate. The healthcare staff returned to the healthcare centre straight after the man had been pronounced dead. They were provided with telephone numbers to contact if they felt they needed to talk to someone. A member of the chaplaincy team came to the healthcare centre that afternoon, but arrived during a clinic and so staff were not able to properly engage with her.
46. Uniformed staff were offered support by the care team on E wing at the time. They were also taken for a hot debrief. However, healthcare staff were not involved and continued to work. Healthcare staff did have a post-incident meeting at a later date. A round-up meeting was also held for staff some weeks after the event.
47. The man's sister was his next of kin. Because of the distance between her address and Wayland, staff contacted HMP Bullingdon (the establishment nearest to where she lives) to request assistance in breaking the news. This call was made at 2.12pm. However, Bullingdon telephoned Wayland at 2.55pm and said they were unable to assist. Wayland then contacted the police, by fax and by telephone, to ask for assistance in informing the sister and to give her a telephone number to contact at the prison. They asked for confirmation that this had been done. The man's sister contacted Wayland at 6.25pm.

ISSUES

Clinical care

48. There were elements of good practice in the man's care, but these were not always evident from the poor records. Not only did this make reading the records difficult, but there were times when it could have affected his medical care. On one occasion, for example, the man was waiting for a dental appointment for a considerable period of time. When he was finally given an appointment, it turned out to be for someone else with the same surname. The man's records also included documents for other prisoners with the same surname. Moreover, both written and electronic records seemed to be kept in parallel which is confusing. Medical record-keeping was a subject on which I made a recommendation in my earlier report and the prison accepted it. I will not repeat it here, but remind the Governor of the importance I attach to this issue.
49. Overall, the clinical reviewers consider that the man received good care in prison. Prison staff were aware of his heart condition and his health was regularly monitored. The main issue of concern is the delay of five days in December 2006 between him complaining of chest pain and being given an ECG. His records do not show if this delay was deliberate, and if so, why. This did not have any effect on his death, but such a delay could have had serious consequences at the time.

The Governor should ensure that any episodes of chest pain are addressed as a matter of urgency.

50. The man's angina was noted on his reception into Woodhill, and he was regularly monitored while he was in prison. However, a clear care pathway does not seem to have been put into place. It is the clinical reviewers' opinion that a care plan should have been drawn up.

The Governor should ensure that care plans are in place for prisoners with cardiac health problems.

Response to the man's collapse

51. Staff responded to the man's collapse very quickly. By good fortune, healthcare staff were on E wing at the time, so the agency nurse was able to reach him with minimal delay.
52. In view of the distance from healthcare to E wing, I am a little concerned at the status of the emergency grab bags and defibrillators on the wings. Defibrillators and full emergency bags had previously been kept on E wing, but had been removed - apparently pending a review of their maintenance. Sadly, it does not appear that this would have made any difference in this man's case. Nonetheless, if equipment is to be replaced, it would be sensible if the new equipment could be in place before the old is removed. I understand that the provision of equipment has been reviewed and I am pleased to learn that there

should now be an adequate number of defibrillators and emergency medical provisions available around the prison.

Support

53. The care team appear to have provided good support for uniformed staff and they attended E wing very quickly. However, healthcare staff had differing views on the support made available to them. Due to staff numbers, they had to return straight to work and were unable to take advantage of support in the immediate aftermath of dealing with the man's collapse. They were made aware of the support available to them, but they would have benefited if the care team had been able to offer them support at the time.
54. Healthcare staff were also not involved in the hot debrief. This could have not only assisted the purpose of the debrief itself, but could have been valuable to those who had just dealt with a traumatic incident.
55. Recommendations about support for healthcare staff and their involvement in hot debriefs were made and accepted in a recent report and I will not repeat them here. But I would draw the Governor's attention to these matters so he can reassure himself that these issues have been addressed.

Informing next of kin

56. It was unfortunate that there was a delay in the man's sister being informed of her brother's death. The Prison Service Order that deals with contacting next of kin in such a situation recommends that such news should be broken to families face-to-face, but recognises that there are a number of factors that mean that each occasion must be assessed individually. The man was pronounced dead at 12.34pm. Staff at Wayland wanted to ensure that his family were informed as soon as possible.
57. Because of the distance between Wayland and the man's sister's home, they contacted Bullingdon to ask if someone would be able to visit to break the news. This telephone call was made at 2.12pm. Staff at Bullingdon telephoned Wayland at 2.55pm to say that they were unable to help. At 3.12pm, staff at Wayland contacted the police by telephone and by fax asking for assistance in informing the man's sister. The police were also given contact details at the prison for the man's sister to use, and asked to let the prison know when she had been informed. The sister contacted Wayland at 6.25pm. The police did not make any further contact with Wayland.
58. It seems to me that staff at Wayland did make proper efforts to ensure that the man's sister was informed personally of her brother's death as soon as possible. However, this did not prevent a significant delay, just short of six hours, from occurring. It was regrettable that staff at Bullingdon were unable to help. However, staff at Wayland should not have left the impetus with the police for so long without following it up

59. As mentioned earlier, I made a similar recommendation in a report that was published in December 2007. The Prison Service accepted that it would review contingency plans to ensure that guidance on how to inform next of kin was included. In those circumstances I will not repeat the formal recommendation here, but I again draw the matter to the Governor's attention. I attach great importance to ensuring next of kin are contacted in as sensitive and as timely a manner as possible.
60. The man's sister was very grateful for the help and support she received from staff at Wayland in the light of her brother's death. She was particularly moved by the memorial service held for him. She asked us to reflect this in my report and I am pleased to be able to do so. I would also like to commend staff at Wayland for the way this was handled.

Issues raised by the man's family

61. As mentioned above, my investigator and family liaison officer spoke to and visited the man's sister. In addition to other issues addressed above, she raised the questions in the paragraphs below.
62. The man did not seem to have many possessions, and his sister asked if there was anything else of his in storage. My investigator asked the prison to check their own and central storage areas. They did so, under both names by which the man had been known, and assured him that there was no further property.
63. The sister was told that her brother had said to another prisoner that he was experiencing pain in his arm and chest, and that he still went running despite the pain. She wondered whether it was possible that he was depressed and that he went running while aware of the possible consequences. My investigator was unable to identify who this prisoner may have been. There were no other indications that the man was depressed or was reckless in regard to his health.
64. The man's sister asked what medication her brother was on and whether he had his own supply or had to collect it each day. The man kept his medication in his own possession, collecting it monthly.
65. The man had gone to hospital for some tests, where it was determined that the medication he was taking for his cholesterol was having an adverse affect on his wider health. He was then taken off this medication and not prescribed anything in its place. His sister asked whether this was an oversight. As mentioned above, his statin was discontinued due to concerns over the effect it might have had on his wider health. His cholesterol level continued to be monitored and the clinical reviewers judge that discontinuing the medication was appropriate.
66. The man's sister was keen that the investigation considered whether the emergency response was timely and carried out appropriately following the man's collapse. The 999 call for an ambulance was made at approximately 11.56am. The Ambulance Service despatched a First Response Unit who

arrived on E wing at 12.17pm. The ambulance arrived at the prison at approximately 12.23pm, with the paramedics arriving on E wing at approximately 12.26pm. The staff nurse asked the PO to ensure in advance that prison gate staff were expecting the emergency responders. She told my investigator that in the three years she had worked in the prison this was probably the fastest transfer of emergency service staff through the prison she had witnessed.

67. The sister asked about the daily regime within the prison. Unlock takes place at 8.00am Monday to Friday and 8.30am at weekends. The man was on an enhanced wing and would not have been locked up as other prisoners would be on the main wings. All prisoners on F wing have free access to other prisoners' rooms until midnight (when they would be expected to be in and remain in their own rooms until unlock the following morning). Prisoners on the enhanced wings have keys to their own rooms allowing free access outside of the curfew times.
68. The sister also asked whether her brother had a television and DVD player in his cell, as several DVDs were among his possessions. The man had a prison issue television in his cell, for which he paid £1 per week. No prisoners in Wayland have DVD players in their cells, but there is a DVD player available for prisoners' use in the main association room.

RECOMMENDATIONS

As I mentioned in my introduction to this report, I have recently made a number of recommendations to Wayland in a report that was not available prior to the man's death. These included the recommendations stressing the importance of medical record-keeping, providing support for healthcare staff, and covering how news is broken to next of kin. The Prison Service accepted these recommendations and I hope that the changes promised have been implemented. In these circumstances I will not make the same recommendations again.

The two separate recommendations emerging from this report are as follows:

The Governor should ensure that any episodes of chest pain are addressed as a matter of urgency.

The Prison Service have accepted this recommendation. A Governor's Notice to Staff is to be issued stating that any prisoner complaining of chest pain should be reported immediately to Healthcare. Healthcare staff will respond in accordance with the National Service Framework cardiac pathway direction.

The Governor should ensure that care plans are in place for prisoners with cardiac health problems.

The Prison Service have accepted this recommendation. National Service Framework cardiac pathways are to be obtained and formulated into patient care plans.