

**Investigation into the death of a man  
at HMP Lewes in December 2009**

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

**March 2011**

This is a report into the circumstances surrounding the death of the man, a prisoner at HMP Lewes.

The man was found unconscious when his cell was opened so that he could collect his evening meal. The officer who discovered the man called for healthcare assistance, and staff and paramedics attempted to resuscitate him. Soon after, however, the paramedics declared that the man had died.

I offer my sincere sympathy and condolences to the man's family and friends for their loss. I am sorry that my report has been delayed and for any additional distress this may have caused.

The investigation was carried out by my colleague. A clinical review of the man's healthcare at Lewes was undertaken by a clinical reviewer on behalf of the East Sussex Downs and Weald Primary Care Trust. I am grateful for his timely review. I would also like to thank the Governor of Lewes and his staff for their co-operation and assistance. Particular thanks go to the two Governor's secretaries, and the prison's liaison officer, for their help throughout the investigation.

The man had served 12 years of a life sentence and had been at HMP Lewes for 18 months. He had been transferred there from an open prison following a change to his security category. I understand he was frustrated by his re-categorisation. However, while the man reported various minor ailments, there were no serious concerns about his well-being until the day of his death.

Although the man's death was due to natural causes (heart attack), I have questioned the medical treatment he received in the hours leading up to his death. Two of the nurses who attended to the man were also subsequently suspended by the Head of Healthcare whilst a healthcare review was conducted. One has since resigned from her position at Lewes.

I make eight recommendations regarding the response to a prisoner with chest pains, life threatening emergencies and contacting the next of kin.

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## SUMMARY

The man was given a life sentence for murder. He had been in several prisons, including those in the open estate, before transferring to HMP Lewes on 29 May 2008. He had a chronically painful left shoulder which was later diagnosed (in July 2007) as early degenerative arthritis. For this reason, the man took paracetamol and ibuprofen daily. Aside from this long term shoulder injury, he did not have many health problems.

Very quickly after arriving at Lewes, the man settled into the prison regime. Staff had few concerns about him and he generally made the most of his time, predominantly by attending computer based workshops. Up until 22 December 2009, the man had not reported having any chest pains to staff or any of his peers.

On 23 December at about 2.00pm, having left his cell on the fourth landing to go his workshop, the man arrived on the second landing and complained of having chest pains and tingling in his left arm. The officer on duty believed he did not look well and immediately contacted healthcare. Soon after, two nurses attended the wing to see the man.

Having explained his symptoms, the man's blood pressure was checked several times and found to be above normal. One of the nurses subsequently administered a GTN spray (to treat angina). After approximately 15 minutes, his blood pressure lowered to what was considered an acceptable level. This was around 2.50pm. The nurse wrote in the man's medical record that he should be reviewed by the prison doctor as soon as possible. Soon afterwards the man returned to his cell to rest.

Around 3.00pm the man alerted staff by ringing his cell bell. He again complained of chest pains and the officer summoned healthcare. Another different nurse attended promptly.

The man was examined and told the nurse about the pain he was experiencing. His blood pressure and pulse were initially high. The nurse talked to the man for a while and he mentioned his old shoulder injury. The man did not display any of the symptoms she expected from someone having a heart attack and believed his pain stemmed from his usual shoulder pain. The nurse wrote in the man's medical record "I have reassured him that he is not having a heart attack". Around ten minutes later, the man's blood pressure, pulse rate and the pain had all lessened. The man was told he would see the prison doctor in the morning, but that he should let staff know immediately if he experienced any further problems.

About two hours later, shortly after 5.30pm, staff began to unlock the wing to allow prisoners to collect their dinner. When the man's cell was opened, he did not respond to the officer who called him. The officer went into the cell and found the man lying on his top bunk facing the wall. He did not respond and a senior officer was called immediately. They checked the man for any signs of life, but could not find any.

An "Urgent Message" call (which indicates a life threatening emergency) was radioed through. Healthcare and other staff arrived quickly. The man was examined by the nurses and no signs of life were found. The nurses immediately began cardio pulmonary resuscitation (CPR), until the paramedics arrived and took over. The paramedics continued CPR but the man was pronounced dead at 6.40pm.

I make eight recommendations in my report. They concern responding to a prisoner with chest pains, life threatening emergencies and contacting the next of kin.

## THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened by one of my colleagues, on 13 January 2010 when he met the Governor of Lewes and some of his staff. Notices of the investigation and terms of reference had already been sent inviting anyone with any information to contact the investigator. One prisoner responded to the notices and was interviewed by my colleague.
2. My colleague also met the Head of Healthcare, representatives of the Prison Officers' Association and a representative of the Independent Monitoring Board. He visited all parts of the prison including the wing where the man lived, and met the prison's liaison officer.
3. The man's prison records, including his medical record, were made available to my colleague during his initial visit to the prison. Additional documents were provided when he returned to conduct interviews at the prison.
4. Two of the nurses involved in the care of the man on the day of his death were subsequently suspended from duty, to allow an internal healthcare investigation to take place. Despite trying to contact both nurses, only one nurse responded who was subsequently interviewed. After the interviews were completed, my colleague fed back his initial findings to the Governor. During the course of this investigation, the internal healthcare investigation was still ongoing.
5. A clinical review of the man's medical care was commissioned from NHS Hastings and Rother & NHS East Sussex Downs and Weald PCT. I am grateful to the clinical reviewer for his review. As part of his review, the clinical reviewer also chaired a Clinical Review Panel meeting at the Primary Care Trust (PCT) Headquarters. He had sight of some of the interview transcripts and the man's medical records. I would like to extend my thanks also to the Consultant Nurse Cardiologist employed by Brighton and Sussex Hospital trust, who attended the Clinical Review Panel to provide an independent opinion into some aspects of the care provide to the man.
6. One of the Ombudsman's family liaison officers contacted the man's family to inform them of the investigation. Later the Ombudsman's family liaison officer met the man's sister at her home to give her the opportunity to raise any questions or concerns about the care her brother received. The man's sister wished to share the following information in respect of her brother.
  - The man's said that her brother had never complained of heart problems. She was aware that he suffered from shoulder pain which she believed was arthritis. She said that the man would have asked for help straight away if he knew something was wrong with him. The man's sister would also like to know if and when the man had ever seen a doctor and if he had been diagnosed with angina.
  - The man's sister was concerned at the accuracy of information given to her about the circumstances of her brother's death. She was initially led to believe by the prison's family liaison officer that the

man had died suddenly. Shortly after this, following a visit from the Governor and the family liaison officer, it emerged that the man had actually been unwell on the day of his death and had been attended to by healthcare staff.

- The man's sister was also concerned that her brother had been given GTN spray (normally used to treat angina) when he had felt unwell and she queried if the nurse believed that her brother had angina. Furthermore, it was written in the man's medical record that he was assured that he was not having a heart attack. The man's sister wanted to know if her brother had asked the nurse if he was having a heart attack and why this comment was made.
  - The man's sister wanted to know how many nurses saw her brother on the day of his death, and whether they were permanent or temporary nursing staff. She also wanted to know why an ambulance was not called earlier and if the man's cell door was locked.
  - The man's sister asked if the clinical reviewer would comment on whether, if the man had received earlier treatment, or if an ambulance had been called by the nurses when they first visited him, the man might have survived his heart attack.
7. Following the issue of the draft report of this investigation, feedback was received from the man's next of kin, the Prison Service and East Sussex Downs and Weald Primary Care Trust. This has been acknowledged and where appropriate the final report has been amended to reflect the feedback received.

## **The man**

8. The man was born in London. He was the youngest of four siblings and worked as a plasterer. He gained qualifications in plastering and an NVQ in bricklaying until an injury in 1997 made him unfit to work.
9. He was married for around 17 years before the marriage broke down. The man had no children.
10. During the man's imprisonment, he attended Creative Writing classes and subsequently went on to achieve Open College Network Certificates. He was popular with his fellow students and was someone who eagerly supported and encouraged others in the group. His classroom teachers described him as always very focussed on his writing and said that he produced insightful and imaginative work. He was awarded two prizes in the short story category in the 2009 Koestler Awards.

## **HMP LEWES**

11. HMP Lewes is a category B local prison serving the courts of East and West Sussex. It accepts both adult men and young adults, and has an operational capacity of 723.
12. In her most recent inspection report, following an announced inspection in August 2007, the HM Chief Inspector of Prisons described Lewes as “reasonably safe”, but with weaknesses in anti-bullying and suicide prevention measures. Drug and alcohol work was described as effective and as having good links with the local community. The HM Chief Inspector of Prisons report particularly commended the extremely good relationships between staff and prisoners. Healthcare provision was described as undergoing a “significant modernisation programme”, with new staff being recruited to provide a broader mix of skills and experience. Primary care was “developing well”.
13. Each prison has an Independent Monitoring Board (IMB) made up of members of the community. The Board’s role is to ensure that the prison is properly run and that prisoners are treated decently. The Board produces an annual report for the Secretary of State. The most recent report from the Lewes IMB commented on how population pressures across the prison estate had resulted in the retention of life sentenced prisoners due to the lack of capacity at lifer centres. The Board said that lifers were waiting a long time at Lewes before moving to an appropriate lifer unit. The Board praised the healthcare unit and detoxification regime.

### **Clinical provision**

14. Since April 2009, healthcare at HMP Lewes has been provided by East Sussex Community Health Services (ESCHS), an arms length organisation from East Sussex Downs and Weald PCT. The current Head of Healthcare of Lewes is seconded to ESCHS, where he is responsible for 38 nursing staff who provide 24 hour care to prisoners. Medical input is provided by a consortium of five doctors (GPs) who provide one to two doctors each morning. These doctors provide primary care clinics, visit the inpatient unit (which has 19 beds) twice daily and give 24 hour on-call cover.
15. General mandatory nurse training is provided by the PCT as part of its historical relationship with ESCHS and specific prison related training is provided in-house. All the nurses receive annual refresher training on emergency response, cardiac emergency response and use of a heart-start (defibrillator) machine.
16. The first nurse (who is mentioned later in this report) completed Extended Life Support training on 21 October 2009, and the second nurse (also mentioned later in this report) attended and completed the same course on 10 June 2009. All staff have annual appraisals.

17. The clinical reviewer comments that staffing levels are generally good with a minimum of four nurses/health care assistants in both outpatients and inpatients from 7.00am to 3.00pm. (In addition there are two specialist nurses from the IDTS (drug treatment) Team and three for the Mental Health In-reach Team from Monday to Friday.) From 3.00pm each day six nurses/healthcare assistants are in duty. On the day of the man's death, the Head of Healthcare confirmed to the investigator that there were six on duty with a good skill mix and grades from three to seven. Of the three nurses that attended to the man on the day and prior to his death, two were permanent members of staff and the other was an agency employee who had worked at the prison for about a year.

### **Category of prisoners**

18. On arrival into prison, prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels of category which are A, B, C and D, with Category A prisoners presenting the highest risk.

### **Multi-Agency Lifer Risk Assessment Panels (MALRAPs)**

19. The Prison and Probation Services have an agreement with the Association of Chief Police Officers for the provision of information regarding prisoners serving life sentences for offences of homicide in England and Wales. The MALRAP meeting is a crucial part of the risk assessment process and enables officers involved in the investigation to review and exchange information about the lifer and to highlight areas of concern at an early stage of sentence. The MALRAP members must include the following staff:

- lifer manager
- wing lifer officer/personal officer
- home probation officer
- police investigating officer(s)

### **Incentives and Earned Privileges (IEP)**

20. The IEP scheme was introduced in 1996 to encourage and reward good behaviour by prisoners. There are three levels: Basic, Standard and Enhanced. Incentives include access to in-cell television, more private cash to spend, being able to wear their own clothes, more time out of cell and access to extra and enhanced visits. Each prison sets its own criteria to reach each level.

### **Previous deaths in Lewes**

21. Since April 2004, the Ombudsman became responsible for investigating deaths in prison custody, I have investigated ten deaths at Lewes before the man. Six were a result of natural causes and the remaining were four self inflicted. I refer to a previous recommendation made in one of these investigations in this report.



## **KEY FINDINGS**

### **Prior to the man's arrival at HMP Lewes**

22. The man was arrested and convicted for the offence of murder committed on 28 January 1998. He was later sentenced to life imprisonment with a tariff of 11 years.
23. He began his prison sentence at HMP Wandsworth. He later went on to be held in nine different prisons before transferring to HMP Lewes in May 2008. During this time, he fully co-operated with his sentence plan, completing programmes designed to address his offending behaviour (such as Anger Management, Enhanced Thinking Skills and Emotive Behaviour Therapy) and meeting the targets set for him by staff. He made positive steps to address his offender behaviour and received good reports from prison staff. The man also used his time constructively by attending a number of workshops and achieving enhanced Incentive and Earned Privileges status.
24. In May 2006, the man was awarded category D status. This followed a Parole Board review where he was given credit for the offending behaviour work he had completed. It was acknowledged that he presented a reduced level of risk to the public. The man subsequently transferred to HMP Blantyre House in February 2007 and was granted regular periods of release on temporary licence (ROTL). These included overnight resettlement releases (where he was allowed to remain away from the prison overnight), all of which were completed without incident.
25. The man's past medical history included a chronically painful left shoulder which he had for many years. He saw an orthopaedic surgeon on 4 July 2007, who diagnosed early degenerative arthritis of his left acromioclavicular joint. The man took paracetamol 500mg two tablets four times daily and ibuprofen 400mg one tablet three times daily.
26. Following an incident on 15 March 2008 whilst the man was on a period of ROTL, the police investigated an allegation of threatening behaviour and affray. His ROTL was suspended whilst the police made their enquiries. He was subsequently charged.
27. On 17 April, having attended Lewes Crown Court, the man was acquitted of the charges against him. However, the Parole Board still had concerns about his conduct. He was returned to closed prison conditions and transferred to Lewes.

### **The man's arrival at HMP Lewes**

28. The man returned to Lewes on 29 May 2008 where he went through the normal reception screening process. A cell sharing risk assessment (CSRA) and a health assessment were completed. As a prisoner serving life, he was allocated a single cell.

29. The health assessment screening included completion of a questionnaire by the nurse which captured information such as his past history, family history, social history and immunisations. His blood pressure was 135/82, he weighed 99kg, measured 6foot 2inches and his girth was 36inches. There is no record of a urine screening despite there being a space for it to be recorded. The nurse also completed a medical statement as "fit" and signed in the space 'signature of medical officer'. In the section on current symptoms, the nurse circled 'chest pain' and added coughing. Despite the form stating that any 'yes' responses should result in a referral to the doctor/relevant clinic, there is no evidence to suggest this was done.
30. The assessment identified no concerns that the man might be at risk of harming himself. He had started a series of dental treatments whilst at Blantyre House which were scheduled to continue in Lewes. It was noted that the man felt frustrated that he had been returned to closed prison conditions, which was also away from his family and friends. Most of the man's health screening was hand written and although sometimes unclear, raised no concerns about his general wellbeing other than those mentioned already. (The investigator established that the healthcare department now keeps its records electronically and record keeping is now clearer and referrals easier to monitor.)
31. No further risks were identified during the man's First Night Centre interview. He told the induction staff that he was an experienced prisoner and wished to opt out of receiving the full prison induction. He again expressed that he was upset at being returned to closed prison conditions.
32. The man was located on C wing. He settled into prison regime well with staff reporting no issues. Comments in his wing history sheet included "the man is a polite chap who is keen to get on with his time using the regime well" to "the man has had a good two weeks, follows wing routine, mixes with select few on wing, and attends education and PICTA (computer education classes) regularly".
33. The man's personal officer (a prisoner's first port of call if they have any questions, complaints or need any advice) on C wing up until late October 2009. At interview with the investigator, she described the man as not a talkative man, but "very opinionated". He mixed with a select few prisoners and regularly attended his PICTA workshops. He never complained of any health problems to her.
34. The first officer concurred with the man's personal officer's perception of the man. She worked on C wing and had frequent contact with him. At interview with the investigator, the first officer said the man was a "very quiet man, didn't really mix with many people and stayed in his cell quite a lot of the time and liked art work". He had been unhappy at being returned to closed prison conditions which was followed by disappointment at being refused parole in November 2009. At The man's request, the first officer had attended the parole review board with him. She noted how upset he was about the decision. The man had mentioned on quite a few occasions to the first officer that he did not

get along with his probation officer, whom he believed was not assisting him effectively.

35. The first Senior Officer (SO) was interviewed by the investigator. The SO said that his role at Lewes was that of the Lifer/IPS manager. This involved managing prisoners who were given either life or indeterminate prison sentences (IPS). As part of his role he would set up and conduct the Multi Agency Lifer Risk Assessment Panels (MALRAP). His responsibility also extended to lifer prisoners who had been recalled to prison after breaching their licence conditions, when he would liaise with the Parole Board as necessary.
36. As a licence recall prisoner, the man spoke with the first SO each week. When The man's parole was refused, the Parole Board identified a number of rehabilitation programmes that he should undertake to address his offending behaviour. Once these were completed, he could apply to return to open prison conditions. In particular, the panel identified a programme called the Healthy Relationships Programme as they judged that the man displayed a lack of skill in handling of relationships and emotional issues. When the SO met the man, they discussed this and his sentencing planning. He described the man as generally a quiet prisoner who did not mix with a lot of the other prisoners. He said he could be a difficult prisoner who questioned everything the Prison Service tried to do for him. The SO said he had not known the man to have had any previous health problems.
37. The man made approximately ten telephone calls to friends and family between 16 December and 21 December. (These were not listened to by the Prison Service until after the man's death). He was in good spirits during each and only mentioned a concern he had regarding his health on 16 December. During this call to a female friend, the man said he was "getting this pain in the shoulder and it's you know where I injured my shoulder". This was followed by him saying "It's where the arthritis, what it is it stretches and goes across my chest and it's like the muscles". The man said he had taken ibuprofen pain killers. He made no further reference to his pain in this or any of the subsequent telephone calls.

### **Events on the day of the man's death**

38. The third nurse who was on duty on the morning of the man's death. He told the investigator that the man attended the healthcare hatch around 8.00am to collect paracetamol and ibuprofen for his back and shoulder pain. The nurse's contact with him was short and once he confirmed his identity, the man was given his medication. The nurse said the man made no reference to experiencing chest pains to him. The nurse had no further contact with The man.
39. The man should have attended his PICTA workshop in the morning, but the workshop was cancelled and so he stayed in his cell on C wing. There were no entries in his wing history sheet denoting any concerns raised about him that morning.

40. At interview with the investigator, a fellow prisoner said he had been in Lewes since March 2009. He first met the man at the PICTA workshop and they became good friends. Although they were on different landings, the man would regularly visit the man and they would have cups of tea together. The prisoner described the man as a “very quiet person” who was sometimes abrupt and did not talk to or trust many others. The prisoner was not aware of the man having any previous or ongoing health problems. He said he did not see the man on the morning of the man’s death.
41. That afternoon, prisoners were unlocked for free-flow about 2.00pm. This is when prisoners go to and from their working activities, attend visits and appointments. A second officer who was working on the second landing (ground floor) working at the gate controlling the flow of prisoners through and off the wing. Two members of staff normally staff each landing. A third officer, who started his shift at lunch time, also assisted with free-flow with a fourth officer.
42. The man left his cell on the fourth landing and began to make his way to his PICTA workshop. He arrived on the second landing carrying some library books in his hand. He approached the first prisoner who was outside his cell, and greeted him. The first prisoner told the investigator that the man did not appear to be his normal self. He looked unwell, was very pale, complaining of chest pains and pins and needles sensation in his arms.
43. The first prisoner said he told the man that he looked unwell and was “greyish” in colour. He sat him down on a box near to his cell that was used to store library books. He went to fetch a cup of water for the man. He asked the man if he was alright, and the man responded ”oh my chest, my chest”. His eyes were rolling back and he looked uncomfortable.
44. The first prisoner immediately called the second officer and informed him of The man’s condition. Having noticed the man sitting down on the wing, the second officer approached him and asked if he was going to his workshop. The man said he was not as he had chest pains and pins and needles in his arms. The second officer told the investigator that he immediately telephoned the healthcare unit so that they could send someone to attend to him.
45. Registered mental health nurse (RMN) who was on duty on that day. She had been working at Lewes as an agency nurse for approximately one year. At interview with the investigator, the RMN said that she was in the outpatients department when she received a telephone call from an officer on C wing. The officer reported that a prisoner on the wing, the man, had complained of having chest pains. The first nurse who was in charge was a registered general nurse (RGN) who was in the healthcare office. The RMN informed her of the telephone call from the officer. The first nurse retrieved the man’s medical notes and had a quick look through them. The two nurses then made their way to C wing.

46. The second nurse did not respond to my request to be interviewed. In her statement to the police following the man's death, the nurse said that she took the lead in asking the man about his health. The RMN stood beside her. The man said that he had a pain in his left shoulder and some discomfort in his chest. Whilst the nurses were attending to the man, the second officer continued to supervise other prisoners. The first prisoner said that the nurses had not arrived straight away when called, but thought they arrived at around 2.25pm. By this time, free-flow finished and he was taken back to his cell.
47. The first nurse checked the man's blood pressure. (It is recorded in the man's medical records that his blood pressure was taken at 2.35pm.) She described the reading as "normal and gave no cause for concern". The RMN told the investigator that the nurses considered the man's blood pressure to be raised. The RMN said that the first nurse repeated the measurement a few times and the man's blood pressure still remained "raised". The RMN suggested they try another sphygmomanometer (a blood pressure device used to measure blood pressure) so that the accuracy of the first readings could be checked. She therefore proceeded to retrieve another device from the C wing treatment room. The man told the first nurse that he had had a similar pain in his shoulder six weeks ago but had not reported it, and the pain then went away. He also said he had taken some paracetamol (pain killers) around 12.00pm that day.
48. Having obtained the second sphygmomanometer, the first nurse rechecked The man's blood pressure. The RMN said that the man's blood pressure was slightly lower than the previous readings, but was still considered high. The first nurse continued to check the man's blood pressure. She told the RMN that she would give The man a dose of glyceryl trinitrate (GTN spray, used to treat angina), and left to get this from the healthcare outpatients department. The RMN said she was not aware whether the nurse asked the man if he had ever used a GTN spray before or if he had a history of angina.
49. The RMN remained with the man. He told her that he had chest pains radiating to his left arm which he associated with an injury he received some years earlier. She asked if he had any problems or worries and he replied "Of course, Miss, this time of the year (meaning Christmas) you know you tend to be worried and stressed out".
50. On the first nurse's return, she administered two puffs of GTN spray to the man. (A GTN spray provides rapid relief to the blood vessels in the heart and can relieve angina/cardiac pain.) This was confirmed at interview with the Head of Healthcare. However, the Head of Healthcare told the investigator that it was not policy in Lewes for any nurse to use a GTN spray or GTN tablets without them being prescribed by a doctor in advance.
51. The second officer returned and checked on the man while the nurses were still present. Asked whether he was okay and comfortable, the man said he was fine. The officer offered to get him a cup of tea and left the nurses checking The man's blood pressure whilst he went to make it. Although the first prisoner was locked in his cell, he could see the nurses attending to the man through the

flap in his door. He shouted towards the man and asked him if he was okay, to which he received the response "I'll be alright".

52. After a few minutes, the man told the nurses he felt slightly better. He remained seated on the box on the landing for a short while before the first nurse suggested that she and the RMN take him back to his cell to lie down. However, the man said he was comfortable where he was and wanted to remain there. The nurse agreed and told the man that he would be seen the following day by the prison doctor. She said that if his pain began to worsen, he should communicate with healthcare through the landing staff. The man was content with this. This information was passed onto the second officer as the two nurses left the wing. The nurses also said they would send someone back in the afternoon to check on the man. (This was recorded in the man's medical record at around 2.50pm.)
53. The second officer went and spoke to the man. He asked him if he wanted to stay out on the landing, something the officer was happy for him to do, so he could be monitored more easily. The man said that he wanted to return to his cell. The officer said that was fine but he should ring his cell bell if he wanted staff assistance. It would appear that the man then made his way back to his cell on the fourth landing shortly after 2.50pm.
54. The SO told the investigator that he walked around during the afternoon showing a new probation officer the layout of the prison. He had not gone specifically to C wing to see the man but, having glimpsed him on the fourth landing (he believed it was around 3.20pm although there is some doubt which I consider later) he decided to introduce the new probation officer to him. The man had just come onto the landing. The SO and the new probation officer approached the man and the SO introduced them. The man did not acknowledge her. By this point, they were standing opposite the man's cell, which was locked. The SO asked the man if he had been out somewhere, to which he responded "healthcare".
55. The SO described the man's normal attitude as always "very sharp and curt". He was a tall man (over six foot) and would "stand in somewhat of a stooped position" with one hand underneath the opposite arm. On this occasion, the SO said the man did not look well and so he asked him if he was alright. The man responded with words to the effect of "my blood pressures up again, thanks to you bastards". The SO asked the man again if he was okay to which he replied "yes, yeah I'm alright, I'm alright". The man went on to question the SO about the programme that he was to undertake soon, something he was not happy about.
56. Their conversation lasted for a few minutes and ended with the man asking the SO if he could unlock his cell so he could go in. The man went in and turned back to face the SO who was stood at the door. The man continued his conversation about the programme. Whilst doing this, he bent over and the expression on his face gave further cause for concern to the SO. He asked the man if he was sure he was alright and whether there was anything he could do for him. The man again said he was fine. Their conversation ended with the

SO saying he would look further into the man's queries regarding the programmes they had talked about. The SO then locked and left the wing. The new probation officer did not speak to the man.

57. As 3.00pm approached, the first nurse and the RMN finished their shift for the day. Before leaving, the first nurse gave a handover to the late duty second nurse and gave her the prison radio.
58. At interview with the investigator, the third officer said he had not seen the man since he was assessed by the nurses. At approximately 3.00pm, the officer responded to the man's cell bell. He answered it immediately and found him sitting on his chair (which was normal) at the back of his cell. The man said he was experiencing pains on the left side of his chest and arm.
59. The third officer said he would contact the healthcare department straightaway and left the man's cell door open. He offered to put the man's chair outside on the landing to make it easier to keep an eye on him. The man refused and said he would be okay in his cell. The officer immediately went to the office and telephoned the healthcare department. He informed them that the man had a problem again and needed someone to attend the wing straightaway. The officer said that the second nurse arrived quickly at the man's cell.
60. At interview with the investigator, the second nurse said she knew that the nurses had earlier visited C wing to see the man. He had complained of having "some pain mostly in his shoulder but some general chest pain". He had been examined and his blood pressure taken and the first nurse had updated his medical records. The second nurse knew that the man's blood pressure had been taken but did not know that he had been given GTN spray. The two nurses said that, when they saw the man, he was okay.
61. At 3.00pm, the second nurse received a telephone call from an officer on C wing, requesting her to see the man. She was the only nurse in the out-patients department at the time and, after locking away the medication, made her way to the wing.
62. When the second nurse arrived (at approximately 3.05pm), the man was initially quite agitated at having to explain his symptoms again with another nurse. He said he had just had a chance meeting with the lifer officer and he was not happy about this. He calmed down and began to engage in conversation. The second nurse told him that, because she had been called to the wing in an emergency, she had not had time to read his medical notes. The second officer who had stayed in the cell in case his assistance was required, described The man as unwell and grey. After a minute or so, the officer left to continue with his other duties.
63. The man told the nurse that he had pains in his left shoulder and chest. The second nurse examined him and took blood pressure and pulse readings. They were 173/102, and 90 respectively. The nurse told the investigator that she considered this blood pressure reading as "a bit on the high side". Although she considered whether his chest pain was heart related, she dismissed this as

the man had not displayed some of the common symptoms of a heart attack, such as being clammy, short of breath or complaining of nausea. He also did not complain of any radiation of pain in his neck or in either arm. The nurse said that the man described his chest pain as an epigastric pain (the area of central abdomen) than a pain in his chest.

64. The second nurse sat and talked to the man. His speech was normal and he smoked whilst walking about in his cell. The nurse said they discussed attendance at smoking cessation courses. In their discussions, she told the man that he was not having a heart attack and he said that it was his shoulder injury, not his heart that he was worried about.
65. After being with the man for ten to 15 minutes, the second nurse checked his blood pressure again (timed at 3.10pm) and noted that it had lowered to 160/92 with his pulse reading at 65. His pain had also reduced. The nurse believed that the man's pain related to the shoulder pain he had told her about. She told the man that "he will see GP in the morning and to call if any more problems". As the nurse would visit the wing around 7.30pm, she intended to check on the man again at that point.
66. Upon leaving the wing at about 3.15pm, the second nurse went to the wing office. She informed an officer that if the man had any further problems, healthcare should be contacted immediately. The man's wing history sheet was updated by wing staff, reading "the man had chest pains today, healthcare came". Shortly after returning to the healthcare department, the nurse updated the man's medical record. She included his blood pressure and pulse readings and further added, "I have reassured him that he is not having a heart attack".
67. Should the time that the second nurse said she examined the man be correct, then it would mean that the SO actually spoke with him just before 3.00pm and not 3.20pm as he estimated. This would seem more likely as the man told the second officer that he would return to his cell after seeing the first nurse and the RMN around 2.50pm. He then spoke to the SO before the second nurse was called. The investigator was unable to check the prison's cell activation log to confirm the time the cell bell was pressed as this information is not recorded.
68. The third officer returned to check on the man about 20 minutes after he left his cell. The man's cell door was still open and he was lying on his bed. The second nurse had left by this time. The officer had been quite busy, and did not know when the nurse had left the wing. He asked the man how he felt and received the response "yes, I'm fine". The officer again said to the man that he was happy to leave his cell door open or he could sit out on the landing. He specifically said this because he had a number of tasks to undertake on the wing, and it would be easier for him to monitor the man if he could see him on the landing. There were also a number of wing cleaners who were carrying out cleaning duties on the landings who would also be able to see the man. The man's response however was "No Gov, I'm fine. I just want to sort of get my head down". The officer then continued with his wing duties.

69. At 4.15pm, the process of free-flow begins again as prisoners return from their activities. This usually takes around 15 minutes during which prisoners are counted in by staff as they return to their cells. Staff then conduct the tea time roll check of the entire wing to ensure that every prisoner is present. All cell doors are locked during this time.
70. The third officer carried out the roll check on C wing. When he arrived at the man's cell, he looked in and saw him lying on the top bunk of the bed. He believed that he was resting. Having completed the roll check, the officer and other staff went for their tea break. When the staff returned, they had a quick briefing meeting and then began to prepare the wing for serving the evening meal.
71. Confirmation was given that the roll check was correct and prisoners could be unlocked to collect their evening meal. The third officer began unlocking cells from the fourth landing, starting with cell number 30. As the man was in cell number 31, this was the second cell that the officer opened. This occurred at 5.45pm.
72. When the third officer opened the cell door, the man still appeared to be resting on his bed. The officer called to the man, saying "dinner". He received no response and so repeated his words. As the man again failed to respond, the officer went inside the cell to check him. As he stood beside the bed he could see the man's hands "clutched" and that his face was blue in colour. The man still did not respond when called. The officer quickly left the cell closing the flap and cell door behind him. He was conscious that other prisoners were now on the landing as their cells had been unlocked. He shouted immediately to a second SO who was downstairs, to come up to the man's cell.
73. At interview with the investigator, the second SO said that he was in charge of C wing. Staff had informed him earlier during the day that the man had experienced chest pains. He was aware that the third officer had kept the man's cell door open to keep an eye on him. The SO said he responded to the third officer's shout by running up the stairs to the fourth landing, arriving at the man's cell within seconds.
74. The second SO found the man lying face down on the top of the bunk with his head facing the cell door. He looked asleep. He checked his pulse, but could not find one. He immediately used his radio and called through "Urgent message" and that immediate medical attention was required. The SO repeated this message to ensure the officer in the Communications Unit was aware of the seriousness of the call. He gave further information including the cell location and the fact that the prisoner inside did not respond.
75. Although both officers were first aid trained, neither had received any recent refresher training. Neither commenced CPR. The second SO said that he thought about attempting CPR, but was interrupted by a number of prisoners approaching the man's door to see what was happening inside. As he tried to ensure that "panic and unrest" did not unfold on the landing, staff from

healthcare arrived. On observing the man, the third officer said that from his colour, it looked as if the “life had already drained out of him”.

76. The Principal Officer (PO) was the Oscar 1 (the officer in charge of the running of the prison) when he heard the message “urgent medical assistance required” over his radio. He told the investigator that he immediately made his way to C wing and was quickly directed to the man’s cell. He was briefed by the second SO on the events that had occurred and was told that the man appeared to have died. Oscar 1 immediately went to the wing office and alerted the duty governor. Oscar 1 also requested that an ambulance was called, just as the healthcare nurses arrived.
77. The second SO said that within two minutes, the second nurse and a third nurse arrived with medical emergency equipment. The second nurse had been in the healthcare unit when she received the emergency call at 5.45pm and collected the red emergency bag to take to C wing. (The red emergency bag contains a number of pieces of emergency medical equipment including oxygen and is quite heavy.)
78. The third nurse was working on C wing when she saw the second nurse coming through with the medical bag. Having been informed by other officers that an emergency call had been reported, the third nurse quickly made her to the fourth landing. She was beckoned to the man’s cell by staff and quickly updated on the situation. The second nurse (because she was carrying the heavy medical equipment) went into the cell as the third nurse was being briefed on the situation. The second nurse said that CPR had not been started at that point.
79. The third officer and the second SO assisted the second nurse and the third nurse put the man into the recovery position. The nurses checked the man for signs of life. He had no pulse and so the second nurse entered an airway and administered oxygen. The third nurse continued to check for a pulse and a blood pressure reading throughout. The man remained unresponsive. The second nurse said that the man was not breathing and his face was mottled. She immediately asked the healthcare assistant, who had now also arrived, to collect the defibrillator (a machine that detects the electrical activity in the heart and gives automated instructions to the user on what to do) from healthcare and bring it to the cell.
80. The man was still on the top bunk bed. The nurses were aware that they needed a hard surface, such as the floor, in order for CPR to be most effective. The cell was already short of space and the man was a big man and this made the nurses believe it would be difficult to lower him to the floor. Wanting to start CPR quickly, the third nurse jumped onto the top bunk bed whilst the second Nurse continued administering oxygen. The nurses continued to administer CPR whilst they awaited the arrival of the ambulance. The third nurse said that, during the time that CPR was being administered, the man showed no signs of life.

81. Oscar 1 said that, as C wing had just been unlocked, it was very busy on the wings. Aware that the nurses were carrying out CPR, he wanted to ensure some privacy was maintained around the man's cell. The second SO and the third officer cordoned off the area around the cell with some screens. The prisoners were locked back into their cells.
82. By the time a member of staff had brought the prison's defibrillator to the man's cell, the first paramedics had also arrived (at 5.57pm) and taken control of the situation. A second ambulance crew arrived at 6.05pm. With assistance from those in the cell, the man was lowered to the floor. The third nurse then left the cell. The paramedics assessed his condition and used their own defibrillator. Resuscitation attempts continued for a further 30 minutes before the man's death was confirmed at 6.40pm.

### **After The man's death**

83. The death in custody contingency plans was immediately instigated by Oscar 1. The paramedics remained on the scene for the arrival of the police and the man's cell was sealed to await their arrival. Arrangement was made to contact all the necessary agencies to inform them of the man's death.
84. The police started to arrive at the prison quickly and began to conduct their investigations. They noted that no-one had been appointed as a log keeper (to record details of those entering and leaving the cell), and so arranged for this to be done.
85. Later that evening, a hot debrief was conducted chaired by the Governor of Lewes. The events were discussed and staff were given the opportunity to talk about their involvement. The staff care and welfare team were also in attendance to offer staff support.
86. Around 7.00pm, the Head of Healthcare was informed of the man's death. He later spoke with the healthcare staff involved and also informed the managing director of the ESCHS. Over the next two days, both the first and the second nurses attended the man before his death, were suspended from duty. This was in order that an investigation could be conducted by ESCHS and the Provider Integrated Governance Committee could consider the events leading to the man's death.
87. At interview with the investigator, the third nurse confirmed that although the prison had a defibrillator machine, it was not initially brought to the man's cell when the emergency was raised. The prison also has an electrocardiogram (ECG) machine which is used to measure the electrical activity of the heart. The Head of Healthcare told the investigator that the ECG was not working at the time of the man's death and a replacement was being sought. However, he said that generally nurses at Lewes were not proficient to use an ECG which would be left for a doctor.

## Contact with The man's family

88. At interview with the investigator, the officer who was appointed as the prison family liaison officer (FLO) said she was contacted at home at around 7.45pm. The FLO was informed that she might be needed to visit that evening to break the news to the man's next of kin. (Later that evening, she was asked to attend the prison the following morning.)
89. As soon as the man's death was confirmed, staff began the task of collating his prison records. The man's next of kin details were checked and appeared to be incorrect. Staff spent the evening through to the night checking the details before being able to identify the man's sister his next of kin, although no contact telephone number was available.
90. The following morning (24 December), the FLO went to the prison and was briefed by the Governor of Lewes and a second Governor. Given that the man's family lived in London and wanting to ensure his sister was told as soon as possible, the prison FLO asked the Metropolitan Police to break the news. This was done almost immediately and at 9.45am, the man's sister telephoned the FLO at the prison.
91. The FLO said she passed on the information that she had been given that morning about the circumstances surrounding the man's death. This was that the man was unlocked for dinner at about 5.45pm and was found lying on his bed. Healthcare and paramedics were called and his death was confirmed at 6.45pm. It was suspected that the man had had a heart attack.
92. The FLO said that she offered to visit the man's sister later that day. However, the man's was very upset and declined. Nonetheless, the FLO said she would contact her each day to update her on any further information that came to hand. The FLO also spoke with the man's brother and the coroner to try and arrange for the family to view the man's body. This caused some difficulty as the coroner's office was closed for a number of days for the Christmas period. When the FLO eventually managed to speak with the coroner on 29 December, she arranged for the family to view the man's body on 31 December. This information was relayed to the family.
93. On 30 December, the FLO telephoned the man's sister and arranged to visit her with the Governor of Lewes on 5 January 2010. On 31 December, the FLO met two of the man's brothers to view his body. They were informed that, once the coroner had released the man's body, preparations for his funeral could be made. They offered financial assistance from the prison.
94. The FLO and the Governor of Lewes arrived at the man's sisters' home at around 10.30am on 5 January. The Governor told them that the man had felt unwell in the morning and staff had kept him off work and had made him a cup of tea. The man returned to his cell where the door had been kept open. Healthcare were called and came to see the man. The man's cell door was then locked about 4.30pm following the return of prisoners from various workshops. He was discovered when his cell was unlocked by staff for tea.

The man's sister was very upset at hearing this further information about her brother and felt she should have received full and accurate information from the start.

95. The FLO told the investigator that she did not know this additional information until the Governor said it at the family meeting. She agreed to find out as much information as possible and spoke to the man's sister again the next day. She gave her further information about the man's Parole Board and probation contacts, as well as discussing the release of her brother's body so that his funeral could take place. The FLO spoke with the man's sister again a number of times, mainly to arrange his funeral.
96. Due to the Christmas period and the varying staff shift patterns, the FLO was unable to contact the landing staff who had contact with the man on the day that he died as quickly as she wanted. When she eventually did so, she was able to obtain additional information regarding the circumstances surrounding the man's death. She contacted the man's sister by telephone on 18 January to give her the additional information. The man's sister was also informed that the nurses who examined the man had been suspended from duty pending an investigation.
97. The man's sister was again very upset at receiving additional information. The FLO told the investigator that it was unfortunate that she did not have all the information to pass on to the man's sister when she first contacted her. Had she gone to the prison immediately she was informed of his death and been included in the hot debrief, the FLO said she would have known more that she was originally told.

### **Post mortem**

98. A post mortem examination concluded that the man died from Acute Myocardial Infarction (heart attack) due to Coronary Artery Atheroma (an accumulation of deposits in the wall of the artery). A toxicology examination performed by Brighton and Sussex University Hospitals found no evidence of alcohol, opiates, benzodiazepines, cocaine, benzoylecgonine (a metabolite of cocaine) or cannabinoids in his blood. Paracetamol was present but not in excess.

## ISSUES

### Clinical care

99. It was agreed by the Clinical Review Panel that, overall, the medical care provided to the man prior to 23 December 2009 was appropriate. The clinical reviewer makes six recommendations in his report and I refer to the most pertinent in my report. The clinical review will be shared however in its entirety with the PCT and is attached as an annex to this report. In addition, I make two further recommendations related to healthcare issues.

### Reception healthcare screening

100. On arrival at Lewes, the man's reception health screening was carried appropriately. The clinical reviewer highlighted a few discrepancies such as the legibility of the nurse's handwriting and some missing information. Although none of this appears to have been related to the man's later symptoms, it is important that initial health screening information is recorded in full, accurately and clearly. I am pleased to note that such problems have now been reduced by the introduction of a new computerised medical records system which has also improved the referral process.

### Healthcare response to the man's symptoms

101. Prior to 23 December, the man's prison medical records do not indicate that he had any signs of any heart related problems. It was, however, clear that he had suffered from long term shoulder pain.

102. The RMN and the first nurse first attended the man on 23 December at 2.00pm and ascertained that he had chest pain and raised blood pressure. Against prison policy, an un-prescribed medication (the GTN spray) was administered by the first nurse. The clinical reviewer comments that the fact that the nurse administered the spray suggests that she suspected he had angina. If this was the case, she should have arranged his urgent admission to hospital or at least have sought advice from the emergency doctor.

103. Given the nature and purpose of GTN spray, the clinical reviewer also suggests that the first nurse should have realised that the drug could lower the man's blood pressure. Indeed, it appears that although the pain reduced, after he saw the nurses, he was still in pain as he made his way back to his cell. This is supported by the description of the man from the lifer manager who saw him on the wing.

104. Administering un-prescribed medications can have serious implications for a patient and is a breach of medical practice. I am aware that the nurse was suspended from duty and subsequently resigned from her position at Lewes. Nevertheless, it is of the utmost importance that all healthcare staff are reminded of their responsibilities with regard to dispensing medication.

**The Head of Healthcare should remind all healthcare staff of the protocols in place, and their responsibilities with regard to, the correct dispensing of medication.**

105. At the clinical review panel meeting held on 20 April 2010, a consultant nurse cardiologist employed by Brighton and Sussex hospital said that the symptoms described by the man sounded fairly typical of someone having heart problems. In a hospital setting, an ECG would have been carried out and in a community setting such as a patient's home or GP surgery, a 999 call would have been made.
106. An ECG recording would normally only take place at the request of a doctor. It is used as a diagnostic aid for medical staff. Unless nursing staff use the machines regularly, they would not have the skills to read and interpret accurately. Paramedics however do have the skills. HMP Lewes does have an ECG machine but, on the day in question, it was out of action. At an interview with the Head of Healthcare, on 20 April 2010 it still had not been repaired or replaced. Although, having said that, there is no evidence to suggest that the nurses even considered using the ECG to possibly assess the man's condition. Furthermore, it cannot be assumed that using an ECG would have necessarily altered the outcome for the man.
107. In a previous investigation the Ombudsman carried out at Lewes in 2006, the following recommendation was made:

“A review of when to undertake an electro cardiogram (ECG) recording and establish a subsequent protocol must be developed in terms of complaints of chest pain or angina. This would also empower nursing staff as part of their triage and management roles following agreed algorithms, as medical staff are not always onsite.”

108. I am disappointed to repeat the recommendation here. It is also important that equipment such an ECG is regularly maintained so that it is available for use in these circumstances.

**The Head of Healthcare should conduct a review of the use of electro cardiograms (ECG) and establish a protocol for action that should be taken to deal with complaints of chest pain or angina.**

**The Head of Healthcare should ensure that medical equipment is checked regularly and in full working order.**

109. Although I cannot be certain whether, had an ambulance been called when the first nurse assessed the man, he would have survived the heart attack, his chances of survival would certainly have been better. This can also be said about the second nurse's later contact. It is imperative that the healthcare department has procedures which provide clear guidelines to staff responding to prisoners complaining of chest pain. Following receipt of the draft report, The man's next of kin felt it was it was important to highlight that a key

component of any chest pain protocol is the requirement that an ambulance is called.

**The Governor and Head of Healthcare, in conjunction with the Primary Care Trust should implement a chest pain protocol across the prison for all staff.**

110. The man complained of being unwell and was assessed for a second time between 3.00pm and 3.30pm, and it is likely that this was due to chest pains of a similar or greater level to those he experienced earlier. The second nurse who examined this time, appears to have assumed it was the man's old shoulder injury that was causing the symptoms. However, the man again had high blood pressure, which she appears to have disregarded.
111. The second nurse knew that the man had been seen by other nurses that afternoon. I believe that she should have read their notes before assessing the man. Whether, had she known that his blood pressure had been high and he had been given GTN spray, this would have altered her assessment, is unknown.
112. From statements from prison officers and another prisoner, it would appear that the man's 'grey' colour and distress were noticeable. Although both received annual refresher training on emergency response, cardiac emergency response and the use of a heart-start machine (defibrillator), neither nurse sought advice from a doctor and they were content that he would be seen by the doctor the following day. I am satisfied that the ESCHS took immediate steps to investigate the nurse's conduct and so make no recommendation here.

#### Cardio pulmonary resuscitation

113. The first two officers who discovered the man did not attempt CPR. The clinical reviewer comments that administering CPR as soon as possible increases the possibility of lives being saved. The officers were conscious of a number of prisoners being out on the landings and wanted to make sure that there was no panic on the wing. Both officers were CPR trained, but neither had recent refresher training. It is important that front line staff have their CPR skills updated regularly so that they feel confident to intervene in an emergency.
114. The healthcare nurses arrived extremely quickly and CPR began initially on the top bunk bed because the nurses were unable to lower the man to the floor, where CPR would be more effective. Although the speed of CPR intervention is to be commended, there were enough discipline and nursing staff who could have lifted the man to the floor before the paramedics' arrived.
115. Although the emergency response from the nurses was timely, they did not bring a defibrillator with them. It is essential that necessary equipment is immediately taken to a life threatening situation to assist resuscitation.
116. All three issues are part of general first aid and life support training and so I recommend the following.

**The Governor should review the need for first aid or basic life support training, including refresher training for staff on frontline duties. All emergency equipment should be brought to the scene as soon as an emergency code call is made.**

## **Log sheet**

117. Prison Service Order (PSO) 2710 section 2.6 states that,

“Once death has been verified by a qualified person, a member of staff must be posted to remain at the scene and keep a record of the names of all those entering the cell, which must be limited only to those directly involved with the incident. Pending the arrival of the police, all relevant evidence must be preserved”.

This is a mandatory instruction but was not carried out by staff and was initiated by the police. This is an extremely important task and staff should be reminded of their responsibilities.

**The Governor should remind staff of the importance of creating a log of events following a death in custody as required by PSO 2710, section 2.6.**

## **Contact with the man’s family**

118. PSO 2710 also states that the Governor should

“Arrange notification to the next-of-kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner giving an accurate factual account of what has happened.”

119. The man’s sister was very upset at not being told the full circumstances surrounding the death of her brother at the outset. She received further details some 13 days later during the visit from the Governor of Lewes. About a week afterwards, further and clearer information was provided by the FLO. This caused great distress to the man’s sister. However, although she was concerned about the amount of information the FLO had provided at the outset, she was pleased with the way the officer carried out her family liaison role. This was demonstrated in the high level of contact the FLO had with the man’s family and her support following his death.

120. The FLO was not instructed to attend the prison on the evening of the man’s death. Had she been required to do so, it is possible that she would have had access to more information and been able to speak to the staff on duty. It is important that prison staff who speak to the bereaved family have all the available information about the circumstances surrounding the death.

121. In other death in custody investigations the Ombudsman has conducted, a summary of the circumstances has been produced very soon after the event by the duty governor and a wing manager, which has then been used by the FLO.

Lewes might find it useful to consider using a similar system should another death occur.

**The Governor and Family Liaison Officer should ensure that following a death in custody there is a system in place to accurately record all relevant information prior to a family visit.**

## CONCLUSION

122. The man had a history of shoulder pain which may have influenced his own view of the pain he experienced. There was no evidence to suggest any previous chest, cardiac or angina history. By administering GTN spray, the nurse implied that his symptoms were heart related. An immediate referral to the prison doctor should have been the next step. It was not. The second nurse who examined the man failed to review his medical records and was not fully aware of his symptoms or the treatment he received in the preceding hour.
123. If the nurses had assessed the man properly and called for a doctor or emergency ambulance earlier, I believe that his chances of survival might have been higher. I recognise that he had no known history of cardiac symptoms, but consider that the nurses should have realised the nature of his illness. The man's prognosis was not helped by the first nurse administering, inappropriately, the GTN spray. Her error was compounded later by the delay using the defibrillator. I am satisfied that there was no deliberate attempt to withhold this information from the man's family. I believe that the omission began because the family liaison officer was not required to go to the prison the night that the man died. It was compounded by staff absences over the Christmas period. Nevertheless a delay of 13 days before the man's family fully understood the problem is, I believe, inexcusable.

## RECOMMENDATIONS

1. The Head of Healthcare should remind all healthcare staff of the protocols in place, and their responsibilities with regard to, the correct dispensing of medication.

**The Prison Service has accepted this recommendation.**

2. The Head of Healthcare should conduct a review of the use of electro cardiograms (ECG) and establish a protocol for action that should be taken to deal with complaints of chest pain or angina.

**The Prison Service has accepted this recommendation**

3. The Head of Healthcare should ensure that medical equipment is checked regularly and in full working order.

**The Prison Service has accepted this recommendation.**

4. The Governor and Head of Healthcare, in conjunction with the Primary Care Trust should implement a chest pain protocol across the prison for all staff.

**The Prison Service has accepted this recommendation.**

5. The Governor should review the need for first aid or basic life support training, including refresher training for staff on frontline duties.

**The Prison Service has accepted this recommendation.**

6. All emergency equipment should be brought to the scene as soon as an emergency code call is made.

**The Prison Service has accepted this recommendation.**

7. The Governor should remind staff of the importance of creating a log of events following a death in custody as required by PSO 2710, section 2.6.

**The Prison Service has accepted this recommendation.**

8. The Governor and Family Liaison Officer should ensure that following a death in custody there is a system in place to accurately record all relevant information prior to a family visit.

**The Prison Service has accepted this recommendation.**