



**Investigation into the death of a man
at HMP North Sea Camp in May 2012**

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

December 2012

This is the report of an investigation into the death of a man, a prisoner at HMP North Sea Camp in May 2012. He was 70 years old. The provisional cause of death statement indicated that he died of acute cardiac failure. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. A review of the man's clinical care in custody was carried out by a clinical reviewer on behalf of the local PCT. Staff at HMP North Sea Camp cooperated with this investigation.

The man suffered from Chronic Obstructive Pulmonary Disease (COPD) and peripheral vascular disease (narrowing of the arteries), but died unexpectedly of acute cardiac failure. I am satisfied that he received a good standard of medical care during his time at North Sea Camp.

However, the investigation also found that the emergency response to the man's collapse was poor: there were no first aid trained officers at the scene, there were delays with healthcare staff attending and a delay in calling an ambulance. While the clinical reviewer indicates that a quicker response would have been unlikely to change the outcome for him, these weaknesses need to be addressed. I note that there was another sudden death at the prison two days after he died and I am satisfied that the emergency response was much better on that occasion.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

December 2012

CONTENTS

Summary	4
The investigation process	5
HMP North Sea Camp	6
Key events	7
Issues	11
Conclusion	14
Recommendations	15

SUMMARY

1. The man received a life sentence in 1999 and had been at North Sea Camp since January 2011. While he was at North Sea Camp, he was diagnosed with chronic obstructive pulmonary disease (COPD) and peripheral vascular disease. He had been prescribed medication for his COPD and undergone angioplasty surgery (stretching of certain arteries). He attended a cardio-respiratory clinic just over a year before his death, but no evidence of heart failure was detected at that point.
2. One morning in May, the man was talking to another prisoner in the conservatory of Jubilee House, when he collapsed. Other prisoners were called to assist, but as Jubilee House was unstaffed and the intercom did not work one of the prisoners had to run to the main gate to report the incident and request an ambulance. Prison staff at the main gate reported the incident first to a senior officer (SO) and then to healthcare. An SO attended the scene before requesting an ambulance. Two nurses in healthcare had to clear and close their clinic before going to the scene of the emergency.
3. When nurses arrived they saw that fellow prisoners had put the man in the recovery position. They asked for assistance with cardiopulmonary resuscitation (CPR), but no prison officer came forward to help as none were trained. One of the nurses and another prisoner began CPR, and the other nurse inserted an airway. The nurses had not brought a defibrillator (a device which measures electrical activity in the body and delivers brief electric shocks to help the heart to re-establish its rhythm) and an officer drove one of the nurses back to healthcare to collect one. By the time she returned with it, it was used once before the ambulance arrived. He was taken to hospital, and was declared dead on arrival.
4. The investigation found that the emergency response was delayed by a variety of factors. There was a lack of a working intercom at the resettlement unit and neither gate staff nor the senior officer called an ambulance when the incident was first reported to them. There was no emergency code system to help ensure that healthcare staff knew what situation they would be tackling, and the healthcare unit had to be emptied of prisoners and locked up before the nurses could attend the scene.
5. The clinical reviewer found that the man received good medical care during his time at North Sea Camp. She noted that, although there were delays in healthcare staff and an ambulance attending the scene, the acute nature of his cardiac failure meant that it was unlikely his death could have been prevented. However, we have made a number of recommendations about emergency procedures at North Sea Camp.

THE INVESTIGATION PROCESS

6. The Ombudsman's office was informed of the man's death on 21 May 2012. The investigator issued notices to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact her. No one came forward.
7. The investigator and an assisting investigator visited North Sea Camp on 24 May. During the visit they saw the resettlement house in which the man lived for six and a half weeks before his death. The investigators spoke to the duty governor, the healthcare manager, a representative from the Independent Monitoring Board, and three prisoners.
8. The local Primary Care Trust (PCT) asked a clinical reviewer to carry out a review of the clinical care the man received while at North Sea Camp.
9. The investigators visited North Sea Camp again on 3 July 2012 and interviewed prisoners who had lived in Jubilee House with the man. They also interviewed six members of staff. On 5 July, the assisting investigator interviewed a further member of healthcare agency staff who had since moved to work elsewhere.
10. HM Coroner for Lincolnshire, Boston and Spalding district was informed of the investigation and provided the results of the post mortem investigation. The Coroner will be sent a copy of this report to assist with his enquiries.
11. One of the Ombudsman's family liaison officers contacted the man's sister on 31 May 2012. She explained the purpose of the investigation and provided the opportunity for the family to identify any concerns about his care at North Sea Camp. His sister told the liaison officer that although his death had been unexpected, he had been happy before he died and that he was looking forward to coming out of prison. His family did not have any concerns about the level of care provided before his death, and they praised the prison's family liaison officer, whose support they described as 'excellent and invaluable'.
12. As part of the consultation process the family received a copy of the draft report. The man's sister said that she hoped the prison would follow up on the recommendations and put changes, such as the emergency code system, in place. The report was also sent in draft to the Prison Service. Their response to the recommendations is included.

HMP NORTH SEA CAMP

12. North Sea Camp is an open prison for category D prisoners near Boston in Lincolnshire. (Open prisons are for those who can be reasonably trusted not to try to escape. Subject to risk assessment, prisoners are able to have release on temporary licence to work in the community or to go on home leave.) The prison holds up to 420 prisoners in six residential units including Jubilee House.
13. The man lived in Jubilee House, one of four detached houses on the edge of the prison's grounds used as resettlement units. Jubilee House is between three and four hundred yards from the main gate. He had moved to Jubilee House from the Llewelin Unit, one of the standard prison accommodation units, six and a half weeks before his death. The units are set up like regular homes to help re-familiarise longer term prisoners in the last 6-12 months of their sentence with basic daily living skills. Prisoners started transferring to the refurbished houses at the end of March 2012. Prisoners in Jubilee House share a bedroom with another prisoner and the rest of the facilities (lounges, kitchens and gardens) are communal.
14. Healthcare at the prison is provided by the local Primary Care Trust and a new healthcare centre opened in 2011. The centre is open from 7.30am to 6.00pm Monday to Friday and 7.30am to 12.15pm at weekends. There are nurse led clinics and a doctor attends three days a week.

HM Inspectorate of Prisons (HMIP)

15. HMIP carried out a short follow up inspection in April 2012 of a full inspection held in 2009. Inspectors found that there had been some improvements in the standard of health services. There were regular audits of prescribing and pharmacy-led clinics and medicine use reviews had been introduced. The inspection in 2009 had highlighted the lack of appropriate first aid training and made a recommendation that all staff should have at least annual resuscitation and defibrillation training. This had been achieved for health services staff but not for prison officers.

Independent Monitoring Board (IMB)

16. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The most recent IMB annual report for North Sea Camp covers the year to 29 February 2012.
17. The IMB noted that the new, purpose built healthcare unit was a huge improvement. However, there were concerns that its location could be a problem for some prisoners who were too ill to walk or who were physically disabled.

Previous deaths at HMP North Sea Camp

18. The man's death was the first at North Sea Camp since 2007. The previous case concerned a death by natural causes and there are no similarities to the man's. There have been two deaths at North Sea Camp since he died.

KEY EVENTS

19. On 26 February 1999, the man was sentenced to life imprisonment. He spent time in various prisons before transferring to North Sea Camp on 20 January 2011. When assessed on reception, no health concerns or history of mental health problems were identified. He said that he had smoked for 54 years.
20. On 4 February 2011, the man reported experiencing breathlessness and pains in both his legs when he walked. He was seen by a prison doctor and referred for blood tests, an electrocardiogram (ECG – which records the heart’s electrical activity) chest X-ray and spirometry (which measures how well someone breathes and can be used to diagnose lung conditions). He was also given advice about giving up smoking.
21. On 25 February, he was seen by a doctor to assess the circulation in his legs, and a referral was made for vascular surgery. The doctor prescribed aspirin and amlodipine (which makes it easier for blood to pass through). He also complained of a lump in his groin which was found to be an inguinal hernia (this is a sac formed by the lining of the abdominal cavity. The sac comes through a hole or weak area in the strong layer of the abdominal wall that surrounds the muscle). A referral was made for general surgery and cardio-respiratory medicine in relation to his breathing problems.
22. The man was seen again by the prison doctor on 16 March. The results of his blood tests and X-ray had been received and he was diagnosed with moderate COPD. He had a chronic cough and difficulty breathing when carrying out any physical activities, including walking, so a referral was made to a cardiologist.
23. At this time, he was regularly attending a smoking cessation clinic and used nicotine patches and varenicline (a drug used to help stop smoking). He told the doctor that he had reduced his smoking to five or six cigarettes a day.
24. The man was seen in the cardio-respiratory clinic at hospital on 27 April. An echo cardiogram was carried out (this is a scan which shows the heart’s structure and how well it is functioning). The scan showed no evidence of heart failure and that it was functioning well. Lung function tests showed moderate airway obstruction consistent with his diagnosis of COPD. He was prescribed a salbutamol inhaler in July 2011 by the hospital, but he did not pick up his prescription.
25. On 31 May, he was seen in the vascular surgery clinic at hospital. He was referred for an angiogram to assess the circulation in his legs (an angiogram allows the arteries to be seen to check for narrowed areas). The angiogram showed the arteries in his legs were blocked and he was advised to stop smoking before any treatment could be carried out.
26. On 3 August, the man’s medication was reviewed and he was prescribed simvastatin (a cholesterol lowering drug). He also presented his outpatient prescription for the salbutamol inhaler. It is not clear from the records, but he does not appear to have received it.
27. The records show that the man managed to stop smoking and on 11 September 2011, he underwent angioplasty (stretching) of the arteries in his legs and stents (to keep the arteries open) were inserted.

28. On 23 February 2012, he attended the smoking cessation clinic at North Sea Camp and said that he had started smoking again because he was sharing a room with a smoker.
29. On 4 April 2012, he transferred to Jubilee House. Before he went he had had some concerns about the move because of the distance from the healthcare unit. The Residential Manager spoke to him about his worries, consulted healthcare and arranged for him to visit the Jubilee Unit to experience it for himself. The manager believed that the man was eventually content with the move.
30. On 1 May, the man visited healthcare because he was wheezing. Although he had been prescribed an inhaler by the hospital many months before, he had not received it. The usual process is for the hospital to write to the prison doctor and for the doctor to order it from the prison pharmacy. It is unclear what happened with the earlier prescription, but he was given an inhaler by a nurse at his appointment on the 1 May 2012. The clinical reviewer states that this delay in using an inhaler would not have accelerated the progression of his COPD – its purpose is to provide relief when symptoms occur.
31. On 18 May 2012, the man was seen by a nurse for a pre-scheduled appointment. He said that he experienced breathlessness when cycling (some prisoners at North Sea Camp have bicycles to get around the site). The nurse decided to prescribe spiriva (an inhaler which improves the symptoms and progression of COPD) and showed him how to use it effectively. He completed a Medical Research Council (MRC) breathlessness scale test which asks participants to rate how certain physical activities make them feel. His score indicated that he experienced breathlessness on exertion or walking up slight hills. A COPD assessment test was also carried out based on a questionnaire. The tests were to provide baseline information so that staff could measure the effects of his new medication. None of the results of those tests or his presentation on the day concerned the nurse either in general or in relation to his placement on the Jubilee Unit. It was known that there were no working intercoms or emergency alarms installed at Jubilee House but, while not ideal, the nurse did not think this was a specific concern. He told the nurse that his symptoms were a lot better and that he was feeling quite well.
32. A prisoner told the investigator that when the man returned to Jubilee House he looked grey and was quiet and not himself. The prisoner reported that the man seemed to cough less than normal the next two nights.

Events of Sunday 20 May 2012

33. On morning in May, the man was seated in the conservatory of Jubilee House talking to another prisoner. The prisoner said that while they were speaking the man took a deep breath, turned red and collapsed. He called other prisoners for help. Another prisoner helped him put the man in the recovery position. Another prisoner also came to help.
34. Jubilee House did not have a working intercom and there was no emergency alarm or telephone. Prisoners are not allowed to have mobile phones, so one of the prisoners tried to use the man's bike to ride to the gate. The bike was locked so he had to run to the prison gate area to raise the alarm. When he left

Jubilee House, the man was having difficulty breathing. The prisoner estimates that it took him five minutes to put his trainers on and to get to the gate.

35. At 9.45am the prisoner reported to the gate staff, two Operational Support Grades (OSGs), that the man had collapsed and an ambulance was needed. OSG A then radioed a Senior Officer (SO), who decided that he needed to see the prisoner himself rather than call an ambulance straight away. The SO instructed the OSG to contact healthcare while he came to the gate. The OSG contacted healthcare by radio and informed a nurse that the man had collapsed. It is unclear what other information was given to the nurse. The nurse told our investigator that the message did not convey any urgency or inform him that the man was not breathing, was unconscious or needed an ambulance. However, the OSG told the investigators that the nurse asked her if the matter was urgent and she told him it was.
36. The SO arrived at the gate shortly after 9.45am and decided it was best to drive to Jubilee House picking up healthcare staff first. OSG B drove to healthcare and the SO radioed ahead to tell them the OSG was coming. The prisoner left the gate to return to the house. The SO followed shortly after in his own car.
37. Two nurses asked the prisoners who were in the healthcare unit to leave, closed the windows, locked up what was necessary and picked up the emergency equipment bags. One equipment bag contained oxygen and the other medication. They estimated the lock up process took approximately five minutes. OSG B was waiting for them in the car outside healthcare and drove them to the gate, to drop off the healthcare keys, and then on to Jubilee House.
38. The SO was the first member of staff to get to Jubilee House at approximately 9.50am. When the SO arrived, the man's colour concerned him. He contacted the gate and asked that they call an ambulance, which OSG A immediately did. The man was on the floor and a prisoner was sat on the floor next to him feeling his pulse. The prisoner told the SO that he had collapsed, that his pulse was weak and his breathing shallow. The SO contacted an operational manager and asked him to come to Jubilee House. The SO checked the house for some first aid equipment, but found that the first aid room did not have a first aid box or any other equipment.
39. At 9.53am, both nurses arrived together with OSG B and the operational manager. Nurse A asked for assistance with CPR but none of the prison staff would come forward as they were not trained. A prisoner therefore helped the nurse and they began CPR at 9.55am. The nurse also gave the man oxygen and inserted an airway. The nurses realised they needed a defibrillator and Nurse B was driven back to healthcare at 9.56am, by OSG B (via the gate to get the keys) to collect one. A prisoner went to guide the ambulance to Jubilee House when it arrived. At 10.01am OSG B arrived back at the scene with the nurse and the defibrillator. Nurse A attached the defibrillator to the man; it advised and delivered one shock. The ambulance arrived at almost the same time and paramedics took over his care, using the defibrillator to deliver two more shocks.
40. The ambulance left Jubilee House at 10.20am and took the man to hospital, where he was declared dead on arrival at 10.32am. (The prison was not informed until 11.17am.)

Contact with the man's family

41. The man's sister was contacted by telephone at 10.04am to inform her that her brother had been taken ill. At 11.45am, the prison family liaison officer and the deputy governor travelled to the sister's house to inform her and the man's mother that he had died. They provided information and support and left contact details. The prison assisted with the cost of the funeral, in line with national guidance. The family liaison officer, in company with another prison family liaison officer and some of the man's friends from North Sea Camp, attended his funeral.

Support for staff and prisoners

42. The prison chaplain offered support to the residents of Jubilee House. It is not clear whether any support was offered more widely in the prison, although prisoners on suicide and self harm monitoring were checked by staff.
43. There was a debrief for staff the following day. A debrief should be held on the day of the incident before the staff go home (a hot debrief). The purpose of a hot debrief is to acknowledge what happened, acknowledge the role of the staff involved, normalise the situation and ensure that any immediate needs of the staff have been met. The investigators asked the staff directly involved whether they believed they had been appropriately supported following the death of the man and no one raised any concerns.

Post Mortem

44. A full post mortem report was not available at the time of writing this report, but a provisional cause of death statement indicated that the man died of acute cardiac failure and ischaemic heart disease.

ISSUES

Clinical Care

45. The clinical reviewer states that the man received a good level of clinical care while at North Sea Camp. She says that he received prompt and appropriate medical care on each occasion that he presented with health problems and concerns. She notes that the clinical record keeping in respect of the man was good.
46. The man had been diagnosed with COPD and peripheral vascular disease; both conditions are related to smoking. The clinical reviewer notes that he was assessed for smoking cessation services and received nicotine replacement therapy and varenicline (known as Champix and used to assist with giving up smoking), but had not managed to give up smoking entirely. He reported that he had reduced to six cigarettes a day. She says that continuing to smoke would have had an adverse affect on his COPD, peripheral vascular disease and the ischaemic heart disease that was discovered after his death.
47. The clinical reviewer confirms that ischaemic heart disease does not always cause symptoms and may not be detected using a “resting ECG examination”. Individuals with ischaemic heart disease are at risk of sudden cardiac events, including heart attack and acute heart failure. She states that the witness account of the man’s collapse is consistent with acute heart failure following a sudden cardiac event. She goes on to say that the chance of surviving a collapse of this nature outside a hospital is very poor.

Emergency Response

48. The clinical reviewer indicates that the nurses attended within eight minutes of being informed of the emergency. However, the actual time from the man’s collapse was much longer.
49. The man collapsed at approximately 9.40am, a member of prison discipline staff attended at 9.50am and healthcare staff arrived at 9.53am and began resuscitation attempts at 9.55am. He did not have any effective intervention, apart from what was provided by the prisoners at Jubilee House, until fifteen minutes after his collapse. This was too long and was caused by the failings outlined below.

Communication

Prisoners housed in Jubilee House were unable to contact the main site (some three hundred to four hundred yards away) unless they visited it on foot or cycled if they had a bike. No phones had been installed, the intercom had never worked and there was no emergency alarm. Prison staff were present on the house only at night and intermittently during the day. Originally prisoners housed in Jubilee House were to be allowed their own mobile phones, and the intercom device was also expected to be working. However, technical problems with the intercom SIM card, and a decision by the National Offender Management Service Security Group that the prisoners should not be allowed mobiles, left Jubilee House residents unable to contact the main site quickly. On the morning that the man collapsed, a prisoner had to go to the gate to raise the alarm, which took approximately five minutes. We understand

that the intercom system has now been repaired, and that there are plans to ensure a member of staff is on duty at Jubilee House at all times.

The Governor should ensure that each of the resettlement houses has facilities to allow residents to make quick contact with the main prison site in an emergency.

50. When gate staff contacted healthcare there was some confusion over exactly what kind of situation they were being asked to attend, other than a collapse. A code system is now used by the majority of establishments to signify what type of emergency is ongoing (for example Code Blue means a prisoner is not breathing). A code system should prevent confusion and allow healthcare and other staff to know what kind of emergency they are dealing with and what equipment to bring.
51. When the nurses reached Jubilee House, it became clear that a defibrillator was required. It is not clear why this was not brought originally. One of the nurses had to travel, by car, back to the gate to pick up the healthcare keys, to healthcare to pick up the defibrillator, back to the gate to drop off the keys and return to Jubilee House. This created yet another delay in getting the appropriate response to the man.

The Governor should ensure that an emergency code system is put in place that clearly conveys the nature of the emergency and what equipment is required, including a defibrillator in appropriate cases.

First aid room

52. The first officer on the scene found the first aid room at Jubilee House did not have any equipment. It is important that appropriate first aid equipment is readily available in the event of an emergency, particularly given the distance of Jubilee House from the main site and healthcare.

The Governor should ensure that first aid rooms at Jubilee House and other units are equipped with appropriate first aid equipment.

Ambulance request

53. At 9.45am a prisoner reported to gate staff that the man had collapsed and required an ambulance. Gate staff would not call an ambulance without a SO agreeing, and the SO would not call an ambulance until he had assessed the prisoner himself. This caused a further unnecessary delay. An ambulance was not called until 9.50am, ten minutes after the man collapsed. There was no need for the SO to see the man for himself before allowing an ambulance to be called. A letter of 17 February 2011, to all governors and directors and Heads of Healthcare, from the Chief Executive of NOMS and the Head of Offender Health, drew attention to the need for quick emergency access for ambulances following the PPO's report into deaths from circulatory diseases. The letter made it clear that it was the responsibility of governors to ensure that a protocol exists at each prison to facilitate the immediate access to both the prison and the individual prisoner when emergency ambulance services are required. It said it was also essential that internal procedures should not waste undue time in summoning emergency assistance and that an ambulance could always be cancelled if it was subsequently found that it was not required.

The Governor should ensure that all staff understand that an ambulance should be called immediately whenever there are grave concerns about the health of a prisoner.

Healthcare response

54. The healthcare department at North Sea Camp does not have a designated response nurse. When the radio calls were received, requesting nurses to attend Jubilee House urgently, the nurses had to ask prisoners to leave the unit, make all the necessary lock ups and leave keys at the gate before going to the scene. We believe one of the nurses should have left for the emergency immediately.

The Head of Healthcare should ensure that when nurses are on duty, one should be designated as an emergency responder and should attend the scene of an emergency without delay.

Resuscitation attempts

55. Prisoners in Jubilee House made commendable efforts to help the man when he collapsed. They put him in the recovery position and supported him until help arrived, which the prisoner went to summon.
56. The SO was the first member of staff on the scene but he did not attempt CPR because he was not trained. When we interviewed the SO (who was on temporary promotion) he had still not had the first aid training that we were told all senior officers in the prison are expected to have. When healthcare staff arrived and began CPR, assistance was requested from the three prison staff present, but none came forward to help – again because they were not trained. We are surprised that prison staff did not volunteer to assist as if even if not trained the nurse would have been able to give direction. In the end it was a prisoner who assisted the nurse. HMIP's report, of May 2009, recommended that all staff should have at least annual resuscitation and defibrillation training. We support this view, particularly as North Sea Camp will often have no health care staff on duty.

The Governor should ensure that all staff have at least annual resuscitation and defibrillation training so that they are able to respond appropriately to an emergency.

57. Despite the delays, the clinical reviewer states that in her opinion a quicker response would not have been unlikely to improve the outcome for the man as "survival from this type of cardiac event is poor, even in the hospital setting where there is immediate access to critical and advanced medical care".

The man's location

58. The medical record shows that the man had long standing COPD, had undergone surgery on his legs and was awaiting a hernia operation. Because of his health problems he had expressed some concern about being located in Jubilee House, which was some distance from the healthcare unit. These concerns were apparently alleviated by the residential manager, but there does not appear to have been any assessment of his health before he was moved to

Jubilee House. We accept that the purpose of the resettlement houses is to help prisoners at the end of long sentences re-familiarise themselves with normal living conditions and it is unlikely that in the community they will have ready access to health services. Nevertheless, we welcome an assurance from the prison that it is now the practice to make a health assessment for prisoners being considered for a move to Jubilee House.

Contact with the man's family

59. The SO took prompt steps to alert the man's family that he had been taken ill. Following his death, the prison family liaison officer was quick to visit his family in person and her detailed log shows that she stayed in frequent contact with them up until the funeral. The family requested that this investigation reflects their gratitude for the support she gave them which we are happy to report.

Support for prisoners and staff

60. The prison chaplain attended Jubilee House very quickly to offer support to the man's housemates. It is unclear whether he had friends in the wider prison community who should have been supported and whether such support was offered. It is a requirement under Prison Service Instruction (PSI) 64/2011 that appropriate support is offered to any prisoners directly affected, including those on suicide and self-harm monitoring.
61. PSI 08/2010 requires that there is a hot debrief following any traumatic incident (a death in custody would be included) before the staff go home. We note that a debrief was held the following day, but the debrief should have been held on the day of the emergency to afford an immediate opportunity for staff to discuss what happened and to provide support for each other.

The Governor should ensure that appropriate support is given to both prisoners and staff following a death in custody.

CONCLUSION

62. The man was an older prisoner with a number of health problems. The clinical reviewer considers that he received good care while in prison.
63. When he collapsed the emergency response was delayed by a number of factors. The clinical reviewer states that a quicker response would have been unlikely to have changed the outcome for him, but the investigation indicated a need for a more efficient response in any future emergency.

RECOMMENDATIONS

The NOMS' (National Offender Management Service's) response to the recommendations is detailed in italics below.

1. The Governor should ensure that each of the resettlement houses has facilities to allow residents to make quick contact with the main prison site in an emergency.

Accepted: An intercom system has been installed and a telephone for staff.

2. The Governor should ensure that an emergency code system is put in place that clearly conveys the nature of the emergency and what equipment is required, including a defibrillator in appropriate cases.

Accepted: The Head of Security and the Head of Healthcare have developed an emergency code system, which clearly conveys the nature of the emergency and what equipment may be required. Defibrillators are now located around the establishment.

3. The Governor should ensure that first aid rooms at Jubilee House and other units are equipped with appropriate first aid equipment.

Accepted: Appropriate first aid equipment is now available including defibrillators in the Jubilee units and around the establishment.

4. The Governor should ensure that all staff understand that an ambulance should be called immediately whenever there are grave concerns about the health of a prisoner.

Accepted: LSS 2.87 will be reviewed and reissued to ensure that all staff are aware of the requirements and procedure for calling an ambulance when there are concerns over the health of a prisoner.

5. The Head of Healthcare should ensure that when nurses are on duty, one should be designated as an emergency responder and should attend the scene of an emergency without delay.

Accepted: A system is in place - one person is designated as the emergency responder and carries a radio. That person will respond immediately in emergency situations.

6. The Governor should ensure that all staff have at least annual resuscitation and defibrillation training so that they are able to respond appropriately to an emergency

Accepted: Defibrillators are now in place and training has begun. The Governor will ensure that all staff receive the training and receive refresher training annually.

7. The Governor should ensure that appropriate support is given to both prisoners and staff following a death in custody.

Accepted: The Governor will ensure that a hot debrief will be held on the day of any such incidents and that members of the Chaplaincy and care team are contacted, if not in the establishment, and asked to attend to support staff and prisoners. The Senior Management Team have been reminded of the requirement for a hot debrief as soon as possible following incidents.