



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP & YOI
Parc in March 2013**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of the man, who died at HMP Parc in March 2013. A post-mortem identified that he died from heart disease and blocked coronary arteries. He was 35 years old. I offer my condolences to his family and friends.

A clinical reviewer was appointed to review the clinical care the man received at Parc. HMP Parc cooperated fully with the investigation.

The man had been in prison for almost a year. He had a history of substance misuse, smoked, was very overweight and, although not confirmed, was possibly diabetic, all of which increased his risk of heart disease. He was also asthmatic. He had never been diagnosed with heart disease and complained of few health problems while in prison.

In August 2012, the man transferred to Parc. He was assessed as fit to participate in exercise and did so reasonably often. In November 2012, his blood pressure was recorded as high yet no further tests were carried out. While his increased risk of heart disease had been recognised when he first arrived in prison, the risk was never explored any further and he was not subject to any additional health monitoring.

The man played a game of football on the day he died. He did not complain of any chest pains or illness afterwards but said he felt tired. Shortly after he returned to his cell another prisoner found him collapsed. Nurses and the prison doctor were unable to resuscitate him.

The man's death was sudden and unexpected, as he had not previously been identified as having heart disease. I am therefore satisfied that staff at Parc could not have predicted or prevented his sudden death. However, the investigation has highlighted a need for more to be done to identify, monitor and potentially treat those at increased risk of heart disease and the need to ensure staff are fully aware of emergency radio codes.

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

October 2013

CONTENTS

Summary

The investigation process

HMP & YOI Parc

Key events

Issues

Recommendations

Service Action Plan

SUMMARY

1. The man was remanded into the custody of HMP Gloucester on 29 March 2012, charged with possession of Class A drugs. He said that he was a drug user and was prescribed methadone (a heroin substitute medication). He was a smoker and clinically obese. He was asthmatic and was recorded as diabetic, although this was never confirmed. He was noted as being at risk of heart disease but nothing further was done to explore this. He was prescribed methadone by the prison doctor. In July, he agreed to start reducing his daily dose.
2. In July 2012, a nurse measured the man's blood pressure and it was slightly higher than normal. No action was taken to monitor his blood pressure further. He moved prisons twice before August 2012, when he was found guilty of the offence and received a two year six month prison sentence. He transferred to Parc shortly afterwards.
3. At Parc the man was assessed as fit to use the gym and participate in physical activities. During his gym induction he declared no health problems which might prevent him from exercising.
4. On 15 November, the man saw a prison doctor to discuss taking part in a rapid methadone detoxification programme. The doctor measured his blood pressure, which was again higher than normal. Although national clinical guidance suggests that patients with high blood pressure readings are offered further tests and monitoring, the doctor did not suggest any further monitoring. This was the last time his blood pressure was measured before his death in March 2013. By the end of November, he had stopped taking methadone.
5. In early December, the man saw a prison doctor and was diagnosed with chronic sinusitis. He was prescribed medication but did not collect it as prescribed, so the prescription was cancelled a few weeks later. He did not see a doctor again before his death or apparently complain of further health problems. In December and January, he missed several booked appointments with nurses for blood tests to help determine whether he had diabetes.
6. One morning in March the man played football for nearly an hour. During the game he had to rest and the supervising officer asked if he was okay. He said he was tired but otherwise fine. When he returned to the wing at 10.50am he chatted to an officer. He did not complain of feeling unwell or having any chest pains but again said he felt tired. Shortly after 11.00am, a prisoner alerted officers that he was unwell. The officers found him collapsed in his cell. Despite the efforts of nurses and a prison doctor, he could not be resuscitated.
7. The man died suddenly and unexpectedly from heart disease and blocked coronary arteries. He had not previously been diagnosed with heart disease although he had some of the known risk factors. We make five recommendations about monitoring high blood pressure, identifying and monitoring prisoners at risk of heart disease, and the use of emergency codes.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Parc to inform them of the investigation and asking anyone with relevant information to contact her. No responses were received.
9. The investigator obtained copies of the man's prison medical records and other relevant documentation. The PCT conducted a review of the clinical care the man received at Parc.
10. The investigator conducted telephone interviews with officers and nurses at Parc in July 2013. She wrote to the Director to give initial feedback about the investigation after the interviews.
11. HM Coroner for Bridgend and Glamorgan Valleys was informed of the investigation and provided a copy of the post-mortem report. This investigation report has been sent to the Coroner.
12. One of the Ombudsman's family liaison officers contacted the man's brother to explain the purpose of the investigation and invite him to raise matters he wished the investigation to consider. His brother wanted to know whether he had complained of chest pains or showed any signs of suffering with heart problems before his death and, if so, whether he was treated appropriately. He also wanted to know about the day of his collapse and whether the prison's emergency response was appropriate.
13. The man's brother received a copy of the draft report; he did not make any comments.
14. The service also received a copy of the draft report. They did not raise any factual inaccuracies. The service response to our recommendations and an action plan are attached in the report.

HMP & YOI PARC

15. HMP & YOI Parc, which opened in 1997, is run by G4S. It holds more than 1,400 convicted male adult prisoners and young adults on remand or convicted. It also has a unit for around 60 young people under 18.
16. G4S provides 24 hour primary general and mental healthcare services at Parc and St John's Medical Practice provides 24 hour GP cover.

HM Inspectorate of Prisons

17. HM Inspectorate of Prisons (HMIP) last published inspection report of Parc is of a full unannounced inspection in September 2010. They found that prisoners were mostly positive about their relationships with staff. Inspectors reported that, at the time, healthcare services were not delivered to an acceptable standard. G4S was about to take over the provision of healthcare services when the inspection took place. The report of a recent inspection has yet to be published.

Independent Monitoring Board

18. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who oversee day-to-day life in the prison to help ensure that prisoners are treated fairly and decently. In its most recent published report the IMB for Parc noted that the prison was well-run and safe, although they identified some problems with prisoners being made aware of medical appointments.

Previous deaths at Parc

19. The man was the ninth prisoner to die at Parc since the beginning of 2012. There are no similarities between the circumstances of the deaths or the recommendations made.

KEY EVENTS

20. On 29 March 2012, the man was convicted of possession of class A drugs and was remanded to prison to await sentencing. He arrived at HMP Gloucester later that day. It was not his first time in prison.
21. At Gloucester, the man told healthcare staff that he used benzodiazepines (sedative medication which is also often used illicitly by those with substance misuse problems) and injected heroin. He said that he was prescribed 65ml of methadone (a heroin substitute medication) a day. He said that he smoked about five cigarettes every day. His lung function was tested and found to be within the normal range. His urine tested positive for methadone, benzodiazepines and cocaine and he was referred to the doctor and the prison substance misuse service. He weighed 120 kg (almost 19 stone) which was recorded as 40kg heavier than his ideal weight. His body mass index (a measure of weight related to height) was 37, which is classed as obese and potentially posing serious health risks. His blood pressure was 114/62 mmHg and within the normal range. He said that he was worried about withdrawing from drugs but saw his imprisonment as an opportunity to stop using them and change his life. He was given 120mg of dihydrocodeine to help relieve withdrawal symptoms.
22. Later on 29 March, another member of healthcare staff at Gloucester entered further information on the man's medical record. They noted that he suffered with asthma and diabetes and was at risk of heart disease. His medical record contains no further mention of diabetes until 2013.
23. The next day, a prison doctor examined the man and noted that he seemed sedated and did not appear to be withdrawing. He said that he had not had any methadone for 36 hours but the doctor thought that he was under the influence of opiates. The doctor decided to prescribe a lower dose of methadone to start with, which could be increased as necessary. He said that his local community drugs team had prescribed him 65ml of methadone for the last few months but that he had recently relapsed because of personal issues to using other drugs. He said that he was using heroin on top of the methadone and had injected it in the past week. The doctor prescribed him 30ml of methadone, rising to 50ml over the course of a week. The doctor checked his blood pressure again and it was 104/62 mmHg and within the normal range. The doctor's entry made no mention of his asthma, diabetes or that he was at risk of heart disease.
24. Later that day, healthcare staff requested the man's community medical record from his doctor. It does not appear that the community records were ever received as they do not form part of his prison medical record. Staff also telephoned his local pharmacy, which confirmed that he was prescribed 65ml of methadone and that the police had collected a dose for him on 28 March.
25. In April, the man began working with the Counselling, Assessment, Referral, Advice and Throughcare Service (CARATS, the prison substance misuse team which provides interventions and services for prisoners with drug and alcohol problems) and participated in group work.

26. On 28 May, the man transferred to HMP Cardiff. Healthcare staff recorded that he was prescribed 60ml of methadone. His blood pressure was checked and was 114/63 mmHg and within the normal range. No mention was made of asthma or diabetes or that he was considered at increased risk of heart disease. On 9 July, he agreed to begin reducing his methadone dose by 5ml a fortnight.
27. The man transferred to HMP Swansea on 20 July. The next day, he was assessed by a nurse who recorded that he smoked between 10 and 19 cigarettes a day. His blood pressure was 145/90 mmHg, which was higher than normal. His daily methadone dose was now 45ml. He told the nurse that he used inhalers to manage his asthma. According to his medical record, he had not been prescribed any inhalers since being remanded to prison. No action was taken in response to the raised blood pressure reading and he was not referred to the doctor.
28. On 13 August, the man was sentenced to two years and six months in prison. On 31 August, he transferred to Parc. A nurse assessed him and recorded that he had no mental health problems or thoughts of self-harm and was prescribed 30ml of methadone a day. He weighed 124kg and said he was fit and well. His blood pressure was not measured and no mention was made of asthma, diabetes or heart disease risk. As part of his initial health screen, he was assessed as having no health problems which prevented him from using the gym or exercising.
29. A doctor examined the man on 1 September. The doctor noted that he was on a methadone detoxification programme and his methadone dose was being reduced by 5ml a fortnight. He said that he had applied to HMP Erlestoke to complete the Twelve-Step programme (a substance misuse recovery programme) and had worked with CARATS at Swansea. He said that he suffered with asthma, which was controlled by beclometasone and ventolin inhalers, which the doctor subsequently prescribed for him. He denied any recent use of illicit substances. The doctor decided that he should continue to receive 30ml of methadone a day for one month while he was waiting to begin work with CARATS. He was referred to the asthma clinic but there are no entries in his record to suggest that he attended the clinic before his death.
30. The man completed a gym induction on 9 September. A physical education manager told the investigator that all prisoners who want to use the gym or take part in physical activities organised by the physical education department have to complete the induction first. He said that all prisoners are offered the induction when they first arrive at Parc. He said that as part of the induction, the prisoners are given demonstrations of gym equipment, told about the rules and regulations of gym use and have to complete a Physical Activity Readiness Questionnaire (known as the PAR-Q). The PAR-Q is a self-completed form focusing on medical history which helps to identify people for whom exercise might not be advisable, or not without further advice from a doctor. A number of the questions ask about known heart problems or experiences of chest pain. The PAR-Q is used in the community as well as in prison and relies on the person completing the form being honest about their health.

31. Parc could not find the man's completed PAR-Q when it was requested by the investigator. The physical education manager told her that he had reviewed it after the man died and that he had not highlighted any existing health problems or experiences of chest pains. He said that prisoners were told that they must inform physical education staff if they later developed any health problems which might affect their ability to exercise safely. He said that the healthcare department always informed the physical education department if a prisoner was assessed as unfit to use the gym or exercise, but that otherwise, physical education staff relied on prisoners telling them about health problems.
32. The man began working with CARATS on 10 September. On 13 September, he saw the doctor again in the substance misuse clinic. He said that he was doing well and wanted to continue to reduce his methadone dose. On 11 October, he received the influenza vaccination.
33. By 15 November, the man's methadone prescription had reduced to 8ml a day. He saw a doctor and asked for a rapid detoxification. The doctor agreed to reduce the dose to 5ml for three days and then stop the prescription. He was prescribed other medication to help treat any withdrawal symptoms. The doctor measured his blood pressure, which was 166/91mmHg, higher than normal. The doctor did not record that any further tests needed to be carried out or that he needed to be prescribed any medication.
34. The next day, the man's cell was searched and he admitted to having illicitly brewed alcohol (known as hooch) in his room. He received 14 extra days on his sentence, suspended for six months, as punishment. He said that he wanted full time work or education and the CARATS worker said she would discuss this with his wing manager. By 26 November, he was working every morning and going to education in the afternoons.
35. On 17 November, the man had an appointment with the doctor because he was coughing up dark brown phlegm. The doctor listened to his chest and recorded that he was wheezing. The doctor prescribed antibiotics and a new inhaler. He also said he had pain at the site of an old finger injury and was prescribed anti-inflammatory medication.
36. The doctor examined the man again on 3 December. He said that he had earache, a headache, a dry mouth and his nose was blocked at night. He said his finger was still painful. The doctor recorded that he had chronic sinusitis (inflammation of the lining of the sinuses) and musculoskeletal pain. He changed one of his asthma medications and prescribed amitriptyline (which at low dose is used to treat arthritic pain) to help treat his finger pain. He was also prescribed nicotine replacement patches to help him give up smoking. This was the last time he was examined by a doctor before his death in March.
37. On 4 December, hooch was found in the man's cell again and he was placed on a basic regime under the Incentives and Earned Privileges (IEP) scheme. (Under the IEP scheme, good behaviour is awarded with extra privileges, and poor behaviour results in some privileges being taken away. There are three levels in the IEP scheme: enhanced, standard and basic.)

38. Between 5 and 21 December, the man often did not collect his prescribed medication from the nurse. On 15 December, a nurse noted that he had been listed as having diabetes on the healthcare computer system but that she could not find any supporting evidence for this. She booked an appointment on 28 December for him to have a blood test to check this, but he did not attend. The amitriptyline prescription was stopped at the end of December because he had not been collecting the medication as prescribed.
39. On 2 January 2013, after a period of good behaviour, the man returned to the standard regime. His personal officer spoke to him at some point in January (the exact date of the conversation is not recorded in the file) and noted that he used the gym whenever he was able to.
40. During January, the man missed three blood test appointments, as well as an appointment with a nurse and a dental appointment. On 5 February, he received a written warning for being late for lock up and another for smoking on the wing. Two days later, on 7 February, he was placed on the basic regime again. On 12 February, he received a third written warning for being late for lock up.
41. On 7 March, the man asked for an appointment with the nurse because he had an infection. There is no further recorded information about this and he did not see the nurse before he died.

Events of the incident

42. One morning in March, the man played football for an hour. The game was supervised by Officer A. Officer B, who worked on B wing where the man lived, told the investigator that he was surprised that he had played football that morning as this was not something he did often. The officer described him as generally seeming quite lethargic and did not think that he frequently exercised. However, the physical education registers for the period January to March 2013 show that he engaged in physical exercise reasonably frequently, although when he was on the basic regime, he was only allowed to participate once a week.
43. Officer A said that the man raised no concerns during the game although the officer overheard him tell another prisoner to stop making him work so hard. The officer said that the football games tended to be energetic and quite physical and that, on 11 March, he saw that he was often chasing after the ball. The officer said that at one point during the game, the man lay down on the floor. The officer asked him if he was okay and he said that he was fine and just needed a break. The officer said that he did not mention having any chest pains and that if he had, he would have immediately called healthcare staff to assess him.
44. The man's personal officer saw him when he returned to the B wing at about 10.50am. The officer said that they sat at a table in the association area and chatted for a few minutes. He told the officer that he was tired after the football game and the officer said he told him to take his time and have a shower. The officer said that he did not mention feeling unwell or having any chest pains and was breathing normally. He said that there were no obvious signs of any problems. He said that he walked past his cell a short time later

and saw him lying on his bed. He told him he was all right and about to have a shower.

45. Officer B said that at about 11.04am, a prisoner - whose name he did not know - called to him for help. He ran to the man's cell and saw him on the cell floor. The officer said that it looked like he was having a fit as his body was convulsing. He spoke to him and shook him, but he did not respond. The officer said that his breathing seemed laboured. The officer was not carrying a radio and called to colleagues nearby for help. He said that another officer responded first and he also thought that the man was having a fit and went to get help. Officer B stayed with him. (The other officer was away from work due to ill health during the investigation and could not be interviewed.)
46. The man's personal officer could not remember how he had been alerted to the emergency but said that someone told him that the man was having a fit. He said that he used his radio to make a "priority call" for healthcare staff to attend. The officer said that, at the time, the prison had recently changed the emergency radio code system and he could not remember the correct code, but that a priority call signifies an urgent situation.
47. Nurse A, the emergency response nurse that day, was in the treatment room in the healthcare centre when she heard a radio call asking for healthcare staff to attend B2 landing. She told the investigator that she went immediately to the incident. She said that the radio message did not give any information about the nature of the incident and she did not take any medical equipment with her.
48. When she reached B2 landing at about 11.10am, officers were waiting to show her to the man's cell. She said that two officers were in the cell with him, who was lying on the cell floor on his right side. The officers told her they thought he had had a fit but, when she arrived, he was no longer convulsing and she said that she immediately realised that he was seriously ill. Nurse B arrived at the cell very shortly after and went to collect the emergency medical equipment, which was stored on the wing. In the meantime, Nurse A checked his pulse and could not find one, nor was he breathing. She said that she told one of the officers to radio a code red call specifying that he was in cardiac arrest and to request an ambulance. In the meantime, the nurse began cardiopulmonary resuscitation (CPR, the delivery of rescue breaths and chest compressions to try and maintain oxygen flow around the body). According to the prison log, the code red call was made at 11.13am and an ambulance was requested at 11.14am.
49. A doctor was also alerted to the emergency and went to B wing to help, arriving at about 11.15am. He later recorded that he examined the man and agreed that he was not breathing and had no pulse. An automated external defibrillator (AED, which, in some circumstances, can deliver electric shocks to re-establish a normal heart rhythm) was used to deliver nine shocks in total but he did not respond. At 11.30am, the doctor injected him with 2ml of naloxone (which reverses the effects of an opiate overdose) in case he had taken an overdose.

50. The ambulance arrived at the prison at 11.30am and the paramedics reached the man's cell five minutes later. Sadly, attempts to resuscitate him were unsuccessful and, at 11.45am, the doctor pronounced that he had died.
51. On 13 March, officers monitoring another prisoner's telephone calls heard him claim that the man had taken mephedrone (a synthetic stimulant drug which was made illegal in 2010) before he died. B wing officers interviewed as part of the investigation said that, to their knowledge, he did not use illicit drugs at Parc.

Results of the post-mortem examination

52. The post-mortem report identified that the man died as a result of ischaemic heart disease and coronary atheroma (the build up of fatty deposits in the arteries, restricting blood flow to the heart). Analysis of samples of his blood showed that he had not recently consumed illicit drugs or alcohol.

Contact with the man's family

53. After the man's death, a chaplain and the Deputy Director went to the man's father's home and informed him of his son's death. His father and the prison staff then went to his brother's house nearby, who said he would inform other family members. In line with national guidance, the prison offered to help with the cost of the funeral.
54. Prison staff had discovered that the man's two teenage daughters were due to visit him at the prison on the afternoon of the day of his death, accompanied by a member of staff from their children's home. Two operational managers went to meet the girls when they arrived and explained that the visit could not go ahead. They were not told the reason as at that time the prison had not yet informed the man's father, who was his nominated next of kin, and they thought it better to wait till he was told. At about 4.20pm, once his father and brother had been told, the manager telephoned the children's home and the mother of one of the two girls who agreed to liaise with the children's home about breaking the news to his daughters.
55. The manager also spoke to the social worker for the man's young son, who agreed to inform him of his father's death. The chaplain then spoke to staff at HMP Eastwood Park, where the man's ex-partner and the mother of his son was serving a sentence. Staff at the prison agreed to tell his ex-partner of his death.

Support for prisoners and staff

56. Officer B said that prisoners on the man's wing were offered support from the chaplaincy team and wing officers. All prisoners being monitored as a risk of suicide and self-harm were reviewed in case they had been adversely affected by his death.
57. Staff involved in the emergency response said that they had been well supported by the prison after the man's death. The Deputy Director chaired a meeting for staff involved in the incident to allow them to talk about events and to offer support.

ISSUES

Clinical Care

58. The local PCT concluded that the clinical care the man received at Parc was equivalent to that he could have expected to receive in the community. They noted that he had not been diagnosed with any heart problems before his death and that it is very unusual for a man of his age (35 years old) to die of ischaemic heart disease. The pathologist who carried out the post-mortem commented that premature coronary artery disease is often the result of heavy smoking and can be associated with previous cocaine use. Coronary artery disease can also be hereditary.
59. The PCT concluded that prisoners should routinely be asked about their family history of serious health conditions such as heart disease, strokes, diabetes and cancer. Where any such family history is known, appropriate follow up tests and monitoring should be arranged. There is no evidence that the man was asked about his family's medical history at Parc, or any of the other prisons he was held at during his remand period. The PCT noted that new patients are routinely asked about their family history when registering at a GP practice. We make the following recommendation:

The Head of Healthcare should ensure that prisoners are asked about family histories of heart disease, stroke, cancer and diabetes during health screens and that any positive response is appropriately followed up.

60. On two occasions in prison, once in July 2012 when he was at Swansea and again on 15 November 2012 at Parc, the man's blood pressure was recorded as higher than normal. The second time, his blood pressure measured 166/91mmHg. According to the National Institute for Health and Care Excellence (NICE) guidelines published in 2011, a reading of 140/90mmHg or higher should result in the patient being offered further tests to diagnose hypertension (the medical term for high blood pressure). If a patient is diagnosed with high blood pressure, it might be appropriate to prescribe medication. Although two of his readings were above 140/90mmHg, neither resulted in any further tests and he was not formally diagnosed with high blood pressure or prescribed any medication.

The Head of Healthcare should ensure that clinicians follow the NICE guidelines for hypertension when a prisoner's blood pressure measures 140/90mmHg or higher.

61. Although the man had not been diagnosed with any heart problems before his death, he was clinically obese and a smoker both of which are known to cause serious health problems. He was prescribed nicotine patches in December 2012 but there is no evidence that, otherwise, he was offered any smoking cessation advice or support and his use of the patches was not subsequently monitored. There is no evidence that any healthcare staff at Parc talked to him about his weight, or gave him any medical advice about the health implications of being overweight or how to adopt a healthier lifestyle.

The Head of Healthcare should ensure that smoking cessation and weight loss advice is given to prisoners when appropriate.

62. The PCT concluded that prisoners who are known to smoke, have a history of cocaine use and other known risk factors for heart disease should be screened for the disease, including checking cholesterol levels and regular blood pressure monitoring. It had not been established whether the man had diabetes, but if so, this would have been a further risk factor.

The Head of Healthcare should ensure that prisoners with known risk factors for heart disease have regular cholesterol and blood pressure monitoring.

The man's participation in physical exercise

63. The man completed the physical education induction in September 2012. As part of that process he completed the PAR-Q which asked him to declare any known health problems. The PAR-Q could not be found so we have not been able to confirm the responses he gave. The physical education manager told us that the man recorded that he had no known health problems which might affect his ability to participate in physical exercise and had no history of chest pains. He had been assessed as fit for exercise by healthcare staff so it seems unlikely that he would have self-identified any problems on the PAR-Q form. Nevertheless, it is a concern that such a document was not kept safe after his death.
64. Prisoners are told that they must inform physical education staff if they have any health problems which might impact on their ability to exercise. The man did not report any concerns to staff. It seems he was a reasonably frequent participant in gym activities and there was no reason for physical education staff to prevent him from exercising on or before March 2013.

Emergency response

65. The man raised no concerns with staff about his health during or immediately after the football game. He was found collapsed in his cell at about 11.04am.
66. The officers who initially responded thought that the man was having a fit. His personal officer radioed for healthcare to attend but said that he did not use a recognised emergency code because, at the time, he was not sure of the correct code. Nurse A said that, because she did not know why a nurse was required, she did not take any medical equipment with her.
67. The man's personal officer told the investigator that he was now confident about the code system and that code blue was used when someone was not breathing and code red indicated that someone was bleeding. Nurse A said that an ambulance was now requested automatically when a code blue call was called and two nurses respond, one of whom is responsible for collecting the emergency medical bag (which is stored on each wing). This procedure is in line with the national guidance contained in Prison Service Instruction (PSI) 13/2013, which became effective on 28 February 2013.

68. Clearly, confusion about the emergency code system and the lack of information given to Nurse A could have seriously impacted on the man's chances of survival. In fact, we are satisfied that there was no undue delay in beginning resuscitation attempts. Officer B first raised the alarm shortly after 11.04am and Nurse A was at the cell by approximately 11.10am. The code red call (the procedure at the time) was made at 11.13am and an ambulance requested one minute later. The nurse had previous experience as an accident and emergency nurse and began CPR as soon as she realised that the man was not breathing. The doctor arrived shortly after and the AED was used to deliver nine shocks to him. The PCT is satisfied that everything possible was done to save him. We accept that the emergency code system had changed and was new at the time of his death but it is important that all staff are confident about the correct emergency code procedure at all times. We make the following recommendation:

The Director and Head of Healthcare should ensure that all staff are aware of PSI 03/2013 and the revised emergency code system at Parc.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners are asked about family histories of heart disease, stroke, cancer and diabetes during health screens and that any positive response is appropriately followed up.
2. The Head of Healthcare should ensure that clinicians follow the NICE guidelines for hypertension when a prisoner's blood pressure measures 140/90mmHg or higher.
3. The Head of Healthcare should ensure that smoking cessation and weight loss advice is given to prisoners when appropriate.
4. The Head of Healthcare should ensure that prisoners with known risk factors for heart disease have regular cholesterol and blood pressure monitoring.
5. The Director and Head of Healthcare should ensure that all staff are aware of PSI 03/2013 and the revised emergency code system at Parc.

ACTION PLAN: The Man – HMP Parc

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that prisoners are asked about family histories of heart disease, stroke, cancer and diabetes during health screens and that any positive response is appropriately followed up.	Accepted	Questions on family histories of heart disease, stroke, cancer and diabetes have been added to the secondary health screen template. All positive responses will be followed up in nurse treatment clinics for blood pressure and cholesterol checks. Advice on smoking cessation and weight loss is given if appropriate.	Completed	
2	The Head of Healthcare should ensure that clinicians follow the NICE guidelines for hypertension when a prisoner's blood pressure measures 140/90mmHg or higher.	Accepted	All prisoners now have their blood pressure checked on the secondary health screen. Guidance has been added to this screen for staff to ensure follow up is arranged within seven days for all prisoners with a blood pressure of above 140/90.	Completed	
3	The Head of Healthcare should ensure that smoking cessation and weight loss advice is given to prisoners when appropriate.	Accepted	All prisoners with risk factors identified in secondary screening such as weight/smoking are given advice and this is followed up by the practice nurses.	Completed	
4	The Head of Healthcare should ensure that prisoners with known risk factors for heart disease have regular cholesterol and blood pressure monitoring.	Accepted	A healthy heart clinic will be introduced. All prisoners with known risk factors will be screened on a weekly basis.	30/11/13	
5	The Director and Head of Healthcare should ensure that all staff are aware of PSI 03/2013 and the revised emergency code system at Parc.	Accepted	A Director's Order has been published followed by a further notice to staff to ensure all staff understand the emergency code system at Parc. In addition, a de-brief will be held after each medical emergency to ensure the correct procedure was followed.	Completed	