PRISONS AND PROBATION OMBUDSMAN for England and Wales

Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in October 2014 at HMP Rochester

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 a man, who died of anabolic steroid related cardiac hypertrophy (thickening of the heart muscle), in October 2014, at HMP Rochester. He was 34 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Rochester was undertaken. The prison cooperated fully with the investigation.

The man was sentenced to ten years imprisonment in 2010 and had been at HMP Rochester since May 2014. He was generally healthy and had little contact with healthcare staff. However, intelligence reports suggested that he was involved in obtaining and using illicit drugs, including steroids and 'Spice' – a synthetic form of cannabis.

One morning in October, a prisoner in the cell next to the man shouted to officers patrolling the grounds, that he sounded unwell. The wing night patrol officer went to his cell and found him lying on the floor, groaning but unresponsive. The officer called for help but did not use an emergency medical code. Other officers arrived quickly, but no one called an ambulance until 1.30am. At 1.55am, his condition declined; he stopped breathing and staff tried to resuscitate him. The first paramedic arrived at his cell three minutes later and administered emergency treatment. At 2.32am, paramedics pronounced him dead.

I am concerned that prison staff did not search the man's cell and carry out drug tests, which were planned in response to the information received in intelligence reports. I am also concerned that the officer who found him did not immediately use an emergency medical code and that it was 20 minutes before the prison called an ambulance. Owing to further delays in despatching an ambulance and the ambulance getting access to the prison, around 50 minutes elapsed between an officer first finding him ill and the first paramedic arriving. We cannot know whether the outcome would have been different if there had been fewer delays in the emergency response, but it would have given him a better chance of receiving timely medical care.

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 **June 2015**

CONTENTS

Summary

The investigation process

HMP Rochester

Key events

Issues

Recommendations

Action plan

SUMMARY

1. The man was serving a ten-year prison sentence for grievous bodily harm and had been at HMP Rochester since 27 May 2014. He was in good health and rarely unwell.

2. In August, prison staff submitted a number of intelligence reports with suspicions that the man was obtaining and using illicit drugs, including steroids and Spice – a synthetic form of cannabis.

3. In August and September, the man's personal officer noticed that his demeanour had changed and he appeared more aggressive and volatile. When she questioned him about this, he insisted that he was fine, but had been suffering from toothache.

4. One morning in October, the prisoner in the cell next door to the man alerted two officers patrolling outside, that he sounded unwell. The wing night patrol officer went to his cell to check on him at 1.08am. He looked through the door observation panel and saw him lying on the floor with blood coming from his mouth. He was struggling to breathe and did not respond. The officer radioed for urgent help but did not use an emergency medical code, which should have resulted in an ambulance being called automatically. He did not go into the cell immediately, but waited for the night manager and other officers. When they arrived, at about 1.15am, they went into the cell and tried to keep him in the recovery position and cool him down. At 1.30am, the night manager requested an ambulance.

5. The man's condition got worse. He appeared to have a seizure then stopped breathing. At 1.55am the officers started cardiopulmonary resuscitation. The first paramedic arrived three minutes later, followed by four more paramedics shortly afterwards. The paramedics administered emergency treatment on the prison landing to allow room, but at 2.32am, they pronounced him dead. Afterwards, staff left his body on the landing for several hours covered by a blanket, until staff acting on behalf of the coroner removed his body.

6. The investigation found that, in response to intelligence reports received in August, security staff had recommended a priority search of the man's cell and a test for steroid use. However, no action was taken. Prison staff did not follow mandatory medical emergency procedures when he was found unwell. The staff should have called a medical emergency code, which should then have led to the communications room calling an ambulance immediately. We are also concerned that staff did not move his body from the view of other prisoners for several hours after his death. We make three recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Rochester, informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. The investigator and a colleague interviewed six members of staff and three prisoners at HMP Rochester on 17 and 18 December. The investigator interviewed three more staff by telephone.

9. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

10. We informed HM Coroner for Mid Kent and Medway of the investigation, who provided the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted the man's family about our investigation. They had a number of questions and points for the investigation to consider, including:

    - Had there had been a change in his behaviour and demeanour the day before he died? Had he complained of a sore back and asked a friend to collect his evening meal? Should staff have identified that something was wrong with him and investigated this sooner?
    - Had there had been delays in opening his cell, calling an ambulance and allowing the paramedic access to the prison? Had staff used any emergency equipment before the paramedic arrived?
    - Although he was a practicing Roman Catholic no one contacted a priest to administer the last rites.
    - Concerns about the length of time it took the prison to notify them of his death, and that they were given incorrect details about the resuscitation attempts and the cause of death.
    - The availability of drugs within the prison and how he was able to obtain them.

12. The man's family received a copy of the draft report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

13. The report was shared with the prison service. They noted one factual inaccuracy, which has been amended accordingly. The action plan has been added to the end of the report.

HMP ROCHESTER

14. HMP Rochester is a category C prison, holding over 640 sentenced men. Healthcare services at Rochester are commissioned and provided by NHS Kent and Medway. Rochester has an old and new site, each with a healthcare centre. A nurse is on duty from 8.00am to 7.30pm Monday to Thursday and 8.00am to 6.00pm Friday to Sunday. GP clinics are held every morning, Monday to Saturday. Outside these hours, they are contactable by telephone during normal working hours, with an on-call rota between 6.30pm and 8.30am.

HM Inspectorate of Prisons

15. The most recent inspection of Rochester was in January 2013. Inspectors found that the use of illicit drugs was very high. A significant number of security information reports (SIRs) were processed efficiently, although follow up action was not always timely. Mandatory drug tests indicated a high level of drug use and more needed to be done to reduce the drug supply. Inspectors were concerned that the level of suspicion testing was inadequate and not being done within the required time.

16. Inspectors reported that there was too much emergency healthcare equipment held in different places, which could cause delays while equipment was collected, or meant that staff attended to prisoners without a full emergency kit. There were additional defibrillators located around the prison for night staff, but they had not been checked for four months. There were always first-aid trained staff at night-time, but not all were trained to operate a defibrillator.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure prisoners are treated fairly and decently. In their most recent annual report, for 2013-2014, the IMB reported concerns about the availability of drugs and contraband in the prison. Staff shortages had reduced the number of routine cell searches and related activities, as security staff covered other duties. However, the IMB considered that the prison had taken considerable steps to intercept incoming items, including erecting external netting near parts of the prison wall, and had worked with police to help prevent the smuggling of contraband.

Previous deaths at HMP Rochester

18. There had been no previous death at Rochester since September 2004. There was another death shortly after the man’s.

KEY EVENTS

19. The man was sent to HMP Chelmsford on 10 January 2011, after being convicted of grievous bodily harm. The next day, he received a ten-year prison sentence.

20. Prison staff and other prisoners described the man as a healthy man, who took pride in his appearance. He received medication for acid reflux (where stomach acid leaks up into the oesophagus), but rarely saw healthcare staff for any other health problems.

21. The man spent some time at HMP Lowdham Grange and HMP Onley during his sentence. On 5 December 2013, he moved to HMP Ford, an open prison. As part of his resettlement plan, he had regular town visits.

22. While he was at Ford, prison officers submitted several security information reports detailing concerns that the man was using steroids and possibly taking the drug 'Spice' (a synthetic from of cannabis which can have severe side effects). He had increased in size, become aggressive and had mood swings. On 15 May 2014, a targeted search of his cell found a quantity of Spice, liquid steroids, a syringe, two needles and £10 in cash. He was moved to HMP Lewes the next day. When he arrived at Lewes, he was involved in protest on the wing, led by another prisoner. He was held in the segregation unit and then moved to HMP Rochester on 27 May.

23. At the man's reception health screen, a nurse identified no mental or physical health concerns, but he said he had a history of infrequent cocaine and cannabis misuse. He lived on C Wing, a residential wing near the perimeter fence, which is a weak spot for parcels of incoming drugs coming over the fence.

24. In early July, the man told staff that he had a chipped tooth. On 15 July, he reported sick for work as it had got worse. An officer noted in his record that he looked clearly distressed. A nurse gave him a painkiller and referred him to the dentist. He saw the dentist on 21 August. (The dentist extracted a tooth on 25 September.)

25. Between 4 and 21 August, prison staff submitted four intelligence reports about the man. Staff suspected he had a mobile telephone (they detected a strong signal coming from his cell and an officer saw him, through the gap in the cell door, using one). The action planned was to conduct a priority search, late at night with a dog, but there is no evidence that this was done. Staff had also received intelligence that he and other prisoners on the wing were involved in criminal activity, obtaining and distributing spice and taking steroids. Staff proposed a urine test for steroid use and he met the criteria, but again no action was taken.

26. On 27 August, the man told a prison GP that he was depressed. The GP prescribed an antidepressant, but recorded no details of the reasons for his depression. The GP told the investigator that he could not remember any details of the consultation.

27. The man took the antidepressant for a few weeks, but then stopped. He told his personal officer that it had made him sleepy so he discontinued it. She noted in

his prison record that she was concerned about recent changes in his behaviour. She told the investigator that in the few weeks before his death, he had changed and had mood wings and was verbally aggressive. His cell was unkempt and smelled of urine.

28. On 29 September, the man telephoned his parents at 2.48pm and spoke to them for around eight and a half minutes. He told them he had hurt his back, but it was an old injury from the gym and that he would rest. He said he had a toothache and needed stronger pain relief, which he would get from healthcare staff. He mentioned no other concerns and the rest of the call was general conversation. After he had spoken to his parents, he tried to ring his girlfriend, but the call went straight to voicemail.

Events of leading up to the incident

29. On 30 September, the man worked in the wing food servery in the morning and afternoon. He did not go to a GP appointment scheduled to discuss why he had decided to stop taking antidepressants. The reason he missed the appointment was not recorded.

30. The man spoke to his personal officer that day about moving to a calmer and quieter wing. He said he was in pain after having a tooth extracted and was waiting to have another taken out. She advised him to ask healthcare staff for pain relief, but she did not know whether he did. She was concerned that he did not seem himself and asked the officer who locked the cells that night to check on him. She also asked him to take particular note of the smell of urine and the condition of his cell. The officer went to his cell and looked through the observation panel, but did not speak to him. He said that he was lying on his bed and seemed fine. The officer reported back to the personal officer that he was well.

31. A prisoner on Headcorn Wing said that two days before the man's death, while they were in the gym, he had complained of severe back pains and his stomach looked very swollen. He then stopped training, which was very unusual.

32. Another prisoner said he gave the man his newspaper just before 6.00pm, as he usually did. He said the man thanked him and said he would see him in the morning. He mentioned that the man had been suffering from toothache for a few days and one of his friends had been collecting his meals for him, but he did not have any concerns about him at that time. However, during the night he heard him making vomiting and distressed noises. This stopped, and then started again a little later.

33. An operational support grade (OSG) was the night patrol officer on C Wing that night. He was based in the wing office on the ground floor, where he completed paperwork and monitored the wing by watching CCTV. At certain times through the night, he patrolled the wing and logged into electronic pegging points to show that he had patrolled as required. When patrolling the wing he was not expected to look into cells and check prisoners.

34. The OSG said that, at 12.20am he answered the cell bell of a prisoner in a cell five doors away from the man. He did not hear or see anything that caused him concern about any of the other prisoners and nothing from him.

35. Two officers were patrolling the grounds of the prison that night. Just after 1.00am, while they were outside C Wing, a prisoner in the cell next to the man's shouted out of his window that he was concerned about him, as it sounded like he was struggling to breathe. He had heard the noises from him for about ten minutes and had tried to talk to him. He said he had banged on the wall and he had initially knocked on the wall in reply, but then stopped. Officer A said she could hear what sounded like loud snoring coming from his window. Officer B went to the wing office window and asked the OSG to check him.

36. The OSG said it took him about twenty seconds to get to the man's cell. CCTV footage shows this was 1.08am. He looked through the door observation panel and saw him lying on the floor. A little blood was coming from his mouth and he was groaning. The OSG could not get a response from him and radioed for urgent staff assistance at 1.10am (according to the communications log). He went back and forth between the cell and the landing stairs to check if staff were arriving and to reassure him that help was on the way. For security reasons, staff on wings at night do not carry standard keys but have a cell key in a sealed pouch, for use in an emergency. However, the OSG did not open the cell.

37. The manager in charge of the prison that night was based in the prison reception in the centre of the prison. He heard the radio call for assistance and went to C Wing. Three officers were waiting for the manager outside the wing, as he was the only member of staff with a master key to the wings. He unlocked the unit and the staff ran to the man's cell. Officer A said she looked through the observation panel and saw him on the floor, holding onto his bin, with blood coming from his mouth. He was still struggling for breath. She opened the cell and the staff went in. It was approximately 1.15am.

38. The manager and Officer A said they repeatedly tried to place the man in the recovery position, but he struggled and kept rolling onto his back. The manager asked him if he had taken anything illicit, but he did not respond. Within minutes his breathing became more shaky and he was gasping for breath. His eyes were closed, his teeth were clenched and he was sweaty. Officer A put on the fan in his cell to try to cool him down. She noted that there was prescribed medication on the chair in his cell and a bag of multicoloured tablets and green powder on the floor.

39. The manager said that he asked two officers to try to keep the man on his side and he then went to the wing office to call for an ambulance. He said that he wanted to use a telephone, as it would be easier to give additional information to the emergency services operator if they asked for any. As he walked down the landing, he asked the prisoners in the cells immediately next to the man's cell if they knew whether he had taken anything illicit, but they said no. One prisoner, a couple of cells down, shouted that he had taken 'Spice and other stuff'. The communications log shows that the manager telephoned the communications room and asked them to call an ambulance at 1.30am. This was twenty-two minutes after the OSG first found him unwell.

40. The OSG in the communications room requested an ambulance. Unfortunately, the emergency services call handler did not allocate the correct priority to the call and dispatched an emergency responder (a single paramedic, who did not have all the equipment necessary to deal with such an emergency). The Ambulance

Service has conducted a serious untoward incident investigation, but this issue is outside the remit of the Prisons and Probations Ombudsman.

41. The manager went back to the man's cell at around 1.40am. The officers were still trying to keep him in the recovery position. He continued to struggle for breath and his face was purple. He then appeared to have a seizure and bit his tongue. The manager tried to pull his head back and used a spoon to try and open his airways. He then drew a massive gasp of breath and stopped breathing. The manager could not feel a pulse, so he started chest compressions, and an officer took over. The officers continued cardiopulmonary resuscitation until the first paramedic arrived. No one had brought an emergency bag or defibrillator to the incident.

42. The manager radioed the communications room at 1.55am to ask about the progress of the ambulance. He was told a paramedic had just arrived and was on his way to the wing. The first responder arrived to the cell at 1.57am, nearly 50 minutes after the OSG's request for urgent assistance.

43. The paramedic administered oxygen to the man and attached a defibrillator, but found no shockable heart rhythm. Staff continued chest compressions while he radioed for additional help and four more paramedics arrived (two at 2.00am and two others at 2.08am). At 2.09am, they brought the man out of the cell and onto the landing to allow them more room to administer treatment. They gave him emergency drugs through an intravenous line. Despite the efforts of staff and the paramedics, the resuscitation attempts were unsuccessful and, at 2.32am, paramedics pronounced him dead.

Family liaison

44. A family liaison officer and a deputy were appointed. The family liaison officer arrived at the prison at 3.50am and spoke to the staff involved in the emergency to get background about what had happened. At 6.45am, after unsuccessfully trying to get information from the police for a risk assessment for a family visit, he decided to go without this. The man had listed one of his sisters as his next of kin and the family liaison officer and deputy arrived at the address they had for her at 8.22am, but found she had moved. They then went to his parent's home, and arrived there at 8.45am and broke the news to them. His parents telephoned his sister and she joined them at 9.18am. The family liaison officer and deputy explained the family liaison process to them and offered condolences and support.

45. The family liaison officer and deputy left at 11.14am, after arranging for the man's family to view his body in the mortuary that afternoon. They provided ongoing support for his family, including a visit to the prison and offered a contribution towards the funeral costs, in line with national guidelines. The funeral was held on 21 October.

Support for prisoners and staff

46. The Governor issued a notice informing staff and prisoners of the man's death. A senior officer debriefed the staff involved in the emergency response and the care team offered them support.

47. Staff offered prisoners the support of Listeners (prisoners trained by the Samaritans to give emotional support to other prisoners). Staff checked prisoners considered at risk of suicide or self-harm in case they had been affected by the man's death. They offered prisoners in the cells adjoining the man's, and his friends, the support of a counsellor.

48. The prison held a memorial service on 14 October, attended by staff, prisoners and the man's family.

Cause of death

49. The post-mortem report showed that the man died from anabolic steroid related cardiac hypotrophy (thickening of the heart muscle, reducing the size of the heart chambers). The toxicology report indicated the presence of steroids. No synthetic cannabinoids were detected.

ISSUES

Clinical Care

50. The man was in good health and rarely ill. In the weeks before he died, he saw a dentist, who extracted a tooth and other healthcare staff about obtaining pain relief for persistent, severe toothache. The clinical reviewer considered that the clinical care he received was equivalent to that he might have expected to receive in the community.

Drug use

51. Unfortunately, prisoners find many ways of obtaining contraband, such as illegal drugs, in prison. Sometimes prisoners smuggle them in, or they are passed through visits, or they are thrown over prison walls to be picked up by prisoners. In some cases corrupt staff can be involved. Prisons have to be constantly vigilant to reduce the supply of drugs and treat drug addiction to help reduce demand.

52. HMP Rochester's drug strategy includes various prison departments, such as healthcare and security, as well as prison managers, working collaboratively to minimise the availability and use of illicit drugs. One of the actions set out in the strategy is to test for drugs and search cells when intelligence suggests a prisoner might be involved in such activity. The Head of Security said that staffing levels were sufficient to carry these out and new procedures were being implemented across the prison to tackle illicit drug use.

53. The man's security record contained various intelligence reports indicating that staff suspected that he was obtaining and using illicit drugs. In the month before he died, four intelligence reports were submitted suggesting that he was involved in drug activity and advising a priority cell search and urine sample test. These did not happen. The Head of Security was not able to explain why, if they had sufficient resources, the targeted search and drug test had not happened.

54. Despite the view of the Head of Security, the wing manager for C Wing told the investigator that there was often insufficient staff to carry out drug tests and cell searches. He said that there had been a reduction in staff and, apart from one dog handler, there were no longer dedicated security staff to conduct searches. The orderly officer in charge of the routine operation of the prison each day was responsible for coordinating cell searches and allocating wing staff to conduct them. Such staff had to be diverted from other duties and, on some days, no one was available. He said that the prison had since recruited another dog handler.

55. We accept that there will always be competing demands for resources in prisons, but are concerned that planned searches and tests that might have identified the man's use of steroids did not take place. While he himself was responsible for using steroids and would have been aware of the risks involved, earlier intervention by the prison to intercept and curtail his illicit access to such drugs, might have helped prevent his death. We make the following recommendation:

The Governor should ensure that recommended actions arising from security intelligence reports such as drug testing and cell searching are completed within the target times.

Emergency response

56. The OSG had a sealed pouch with a master key to open cells. In line with national Prison Service instructions, Rochester's protocol states that the sealed pouch should be opened to enter a cell alone only in a life-threatening emergency. Staff are not expected to take action which they feel would put themselves or others in unnecessary danger. When he checked the man at 1.08am he was having difficulty breathing, was bleeding from his mouth and was unable to respond to him. The OSG said he did not consider the situation to be life- threatening at the time and for his own safety (in case the man was feigning illness) he did not open the cell and go in. He decided to wait until help arrived.

57. While we understand that it is difficult for staff in such situations to make decisions quickly, we are surprised that in the circumstances that the OSG did not go into the cell. Nevertheless, we accept his assessment. He quickly summoned help from the night manager and other staff arrived soon. Had he gone into the cell, we accept that there would have been little that he could have done for the man. However, we are concerned that he did not use a medical emergency code.

58. Prison Service Instruction (PSI 3/2013) requires prisons to have a medical emergency response code protocol, which states how staff communicate the nature of a medical emergency, and that the control room calls an ambulance immediately when a code is used. It requires no "unnecessary delay in escorting ambulances and paramedics to the patient or discharging them from the prison, including during the night state". Rochester's local emergency response codes protocol states that a code blue should be used if the prisoner is unconscious, not breathing, having chest pain or having difficulty breathing, and the communications room should automatically call an ambulance.

59. When the OSG arrived at the cell, he radioed for urgent staff assistance, but did not use an emergency code. The night staff who responded said they knew they needed to get to the cell immediately, but did not know it was a medical emergency. As staff did not know what they were responding to, they did not take the appropriate equipment, such as the emergency bag and defibrillator. Although the night manager and several officers went to the cell, no one called an ambulance until twenty minutes after the man was first found unwell. This was an unacceptable delay.

60. The ambulance log shows the paramedic arrived at the prison at 1.44am, but it appears he did not find the entrance until ten minutes later. It is not clear why he could not find the entrance gate, but the manager told the investigator that it was not an isolated incident, as paramedics had previously gone to the old prison gate rather than the new one. They sometimes used the postcode, which sends them to a different location. Because of low staffing levels at night, no staff were available to go outside the gate to meet the paramedic. We consider there is a need to ensure that the local ambulance service is fully briefed about how to get to the prison, that the entrance is clearly signposted and the control room staff direct ambulances clearly to the main gate to help minimise delays.

61. It is not possible to say whether the outcome would have been different if paramedics had arrived sooner. However, if a code blue had been called and an ambulance requested straight away at 1.10am, it is likely the paramedics would have reached the man before his condition declined and he needed cardiopulmonary resuscitation. This would have given him a better chance of receiving appropriate medical care. The prison needs to ensure that all staff understand the importance of a swift emergency response whenever there are serious concerns about the health of a prisoner. We make the following recommendation:

    The Governor should ensure that all prison staff are aware of and understand their responsibilities during medical emergencies. Staff should use an emergency code immediately when there are serious concerns about the health of a prisoner and an ambulance should be called automatically and appropriately directed to the prison to avoid delay.

Respect for the dead

62. After the man was pronounced dead, staff covered him with a blanket and left his body on the landing, where paramedics had administered emergency treatment. His body remained there for some hours until undertakers acting on behalf of the coroner took him away. The prison explained that they did not move his body from the landing as they had to preserve the location as a potential crime scene. We understand the need to comply with the expectations of the police and the coroner, but we consider it would have been appropriate to move his body back into his cell for dignity and respect and to reduce the distress to other prisoners who could see him.

63. If a crime had been committed, then the cell would be the more likely crime scene, rather than the landing where emergency treatment took place. In many deaths in prison, emergency treatment is carried out on the landing, but when a prisoner dies, the body is returned to the cell until undertakers take the deceased's body away. This is a matter of sensitivity and the decision to leave the man's body on the landing added to the distress of his family.

64. The man's family were also concerned that, although he was a practicing Roman Catholic, no one considered calling a priest to administer the last rites. However, it would have been very difficult for the staff engaged in the emergency response to have identified his religious affiliations and involved the chaplaincy in time, particularly taking into account that the events took place at night with few staff on duty. Nevertheless, we consider that, where possible and appropriate, prison staff should consult a chaplain about the religious expectations and cultural norms of particular faiths after a death.

    The Governor should ensure that after a death, appropriate privacy is provided to allow the deceased's body to be treated with dignity and respect and that, in so far as possible, religious and cultural sensibilities are considered.

Contact with the man's family

65. The man's family was distressed that there was a delay of nearly six hours before they were notified of his death. We acknowledge and understand their distress. However, the family liaison officer needed first to come to the prison in the early hours of the morning and obtain information from those involved in the emergency response. The distance from the prison and the man's sister's change of address also added to the time it took. Much of the delay was caused by having to wait for information from the police, which is a standard requirement for risk assessment for prison staff in such situations. When it was apparent this was taking too long, the family liaison officer made a pragmatic decision not to wait any longer. It is unfortunate that this took so long, and we agree it ought to have been possible to inform them sooner, but in the circumstances, we do not consider that this was an unreasonable delay.

66. The man's family were also concerned that the prison's family liaison officers had given them incorrect information about how long staff had attempted to resuscitate him and had said that he had suffered a heart attack, although the cause of death was not known at the time.

67. The family liaison log indicates that, before visiting the man's family, the family liaison officer spoke to the prison staff involved in the emergency response and the ambulance crew to find out as much as possible about the circumstances and what had happened, in order to be able to give them as much information as possible. The family liaison officer explained his understanding of events, including the paramedics' view that he appeared to have had a seizure and then suffered a heart attack. He emphasised that the events and timings were approximate, but his death would be fully investigated and they would be given more details as it became available. We are satisfied that the family liaison officers passed on the information they had been given at the time and made clear that this was provisional and would need to be verified.

RECOMMENDATIONS

1. The Governor should ensure that recommended actions arising from security intelligence reports such as drug testing and cell searching are completed within the target times.

2. The Governor should ensure that all prison staff are aware of and understand their responsibilities during medical emergencies. Staff should use an emergency code immediately when there are serious concerns about the health of a prisoner and an ambulance should be called automatically and appropriately directed to the prison to avoid delay.

3. The Governor should ensure that after a death, appropriate privacy is provided to allow the deceased's body to be treated with dignity and respect and that, in so far as possible, religious and cultural sensibilities are considered.

Action Plan			
No	**Recommendation**	**Accepted/Not Accepted**	**Response**
1	The Governor should ensure that recommended actions arising from security intelligence reports such as drug testing and cell searching are completed within the target times.	Accepted	A review has taken place to ensure that this recommendation is met and action taken in line with Prison Service Order 3601 Mandatory Drug Testing, paragraph 4.24 states, "The best results from on-suspicion testing will be obtained when tests are conducted as soon as possible after the action that gave rise to suspicion. A number of prisons have reported conducting on-suspicion testing weeks after the suspicion was highlighted. Clearly, it is much more difficult to justify a test so long after the event. Whilst prisons may have resource difficulties in scheduling tests, unless there are exceptional circumstances, on-suspicion tests should not be conducted more than three days after the SIR was logged". The local review has led to the following change in practice. The Band 4 Intelligence Analyst now reviews all new Mercury Intelligence Reports each morning. Where there is drug related activity a Suspicion Test authorisation is immediately raised to schedule the test within the 3 day time limit.
2	The Governor should ensure that all prison staff are aware of and understand their responsibilities during medical emergencies. Staff should use an emergency code immediately when there are serious concerns about the health of a prisoner and an ambulance should be called automatically and appropriately directed to the prison to avoid delay.	Accepted	A notice to staff will be re published in accordance with Prison Service Instruction 03/2013 Medical Emergency Response Codes. This notice to staff is shared via the local intranet. The local protocol, as required by PSI 03-2013 will be reviewed to ensure that it addresses each of the concerns raised here, and if amended, a notice to staff will be

			Action Plan
No	**Recommendation**	**Accepted/Not Accepted**	**Response**
			placed on the intranet to advise staff of the updated version.
3	The Governor should ensure that after a death, appropriate privacy is provided to allow the deceased's body to be treated with dignity and respect and that, in so far as possible, religious and cultural sensibilities are considered .	Accepted	In line with Prison Service Instruction 51/2011 "Faith and Pastoral Care paragraph 16.2, staff will be reminded of the requirement as part of the death in custody contingency plans to allow, where ever possible, the appropriate chaplain, to undertake any religious rituals following a death. The Police Liaison Officer will be contacted to confirm that the police have no objections to prison staff returning the deceased to their cell and that they would not see this action as an interference with a potential crime scene. Once the police confirm this a notice to staff will be issued.