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 at hospital in January 2013, while a prisoner at HMP Thameside

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. He died in hospital in January 2013, while he was a prisoner at HMP Thameside. His cause of death was given as a pulmonary embolism. He was 47 years old. I offer my condolences to his family and friends.

A clinical reviewer was conducted of the clinical care the man received in custody. HMP Thameside cooperated with this investigation. I am sorry that the issue of this report has been delayed because of the need to wait for post-mortem toxicology results.

The man had been in custody for almost three months when he died. He had asthma and sleep apnoea but no other significant medical problems. He collapsed three times in a very short space on time on the day he died, but an ambulance was not called until his third collapse. The clinical reviewer considers that the response of prison healthcare staff was poor and he does not consider that the clinical care he received at Thameside was equal to that he might have expected in the community,

While it does not appear that the man's sudden death could have been predicted or prevented, the investigation has identified a number of learning points. These include the need for better assessment of fitness to use the gym, the improvement of radio communication during an emergency incident and the avoidance of unnecessary delays in getting paramedics to the site of an emergency.

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 Thameside

Key events

Issues

Recommendations

SUMMARY

1. The man was remanded to HMP Thameside on 11 October 2012. He was noted to have asthma and sleep apnoea (an abnormal breathing pattern when asleep), but no other significant medical issues. He joined the prison gym on the 16 October. Records show that he attended for weights and cardio vascular training over 20 times before his death in January, although there was no clear assessment of his fitness.

2. One morning in January, the man collapsed on his way to the gym. He was assisted by officers and another prisoner until nurses arrived from the healthcare centre. He lost consciousness but recovered and staff decided to help him back to his wing. However, he collapsed again before leaving the gym area. Healthcare staff took observations and, when he regained consciousness, he was taken in a wheelchair to a treatment room on his houseblock.

3. One of the nurses made an appointment for him to see a doctor the next day, and he was asked further questions about his health and observations were taken. He wanted to return to his cell and one of the nurses accompanied him, but on the way he collapsed for a third time.

4. At approximately 10.47am, an ambulance was called and, at 10.51am, another was called. The first ambulance and a paramedic arrived at the prison at 11.01am but took almost eight minutes to get through prison security and to the houseblock. A second ambulance arrived at 11.05am. Paramedics treated the man and he was taken to hospital, arriving at 12.05pm. Attempts to resuscitate him continued for some time at the hospital, but he was pronounced dead at 13.26pm.

5. The prison contacted the man's brother at 12.20pm to inform him that he was gravely ill. He died at 1.26pm and unfortunately his brother had not reached the hospital by this time. The prison's family liaison officer telephoned the man's brother the next day. He remained in contact with the family and offered support.

6. Although it would have been difficult to predict or prevent the man's death the clinical reviewer is concerned about the healthcare response. He found that the clinical decision making about his collapses was poor. Because of this, he does not consider that the clinical care he received at Thameside was equal to that he might have expected in the wider community. We are also concerned that there was insufficient assessment of his fitness to use the gym, some confusion with radio communication during the emergency incident and the ambulance was inappropriately delayed by prison staff when it arrived. There were also some problems identifying his next of kin details and giving the family correct information about the circumstances of his death. Finally, not everyone involved in trying to help him was offered appropriate support. We make seven recommendations.

THE INVESTIGATION PROCESS

7. 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.

8. The investigator visited HMP Thameside on 17 January and spoke to the Director, the NOMS contract controller, the Head of Healthcare, the prison's family liaison officer, a union representative, the gym supervisor and the man's wing supervisor.

9. The local PCT asked a clinical reviewer to carry out a review of the clinical care the man received at Thameside. The clinical reviewer received a copy of the man's prison medical record.

10. One prisoner was interviewed by telephone on 13 January. The investigator and clinical reviewer interviewed five members of staff and two prisoners on 12 March.

11. HM Coroner for London Inner South provided the results of the post-mortem examination and has been sent this investigation report. The Coroner informed us of the man's name as recorded his birth certificate.

12. One of the Ombudsman's family liaison officers contacted the man's brother to explain the purpose of the investigation and allow him to identify relevant matters which he wished the investigation to consider. His brother asked:

    - Whether prisoners who were at the scene when his brother collapsed had useful information?
    - What the sequence and timing of events was and whether the response was adequate?
    - Whether CCTV was available?
    - Whether he could have been contacted sooner about his brother's collapse?

13. The man's family received a copy of the draft report. The solicitor representing the family wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

14. The Service also received a copy of the draft report and raised some minor factual inaccuracies. The report has been amended accordingly. The service response to our recommendations and action plan is included in the report.

HMP THAMESIDE

15. HMP Thameside is a local category B prison that can hold up to 900 convicted and remanded male prisoners. It opened on the 27 March 2012 and is run by Serco.

16. Harmoni for Health provide healthcare services at Thameside. Qualified nurses are available 24 hours a day. GP clinics are held each day except Sunday and GPs provide an out of hours service, if required. Specialist clinics are run, including dentistry, physiotherapy and a psychology service.

HM Inspectorate of Prisons

17. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Thameside in January 2013. HMIP noted that healthcare did not carry out health needs assessments and inspectors were not assured that the services provided met prisoners' needs. HMIP considered that healthcare record keeping was poor, clinical supervision was described as being in 'its infancy' and nursing staff were witnessed not listening to patients and being dismissive and rude.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB), of unpaid volunteers from the local community, who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. The IMB has not yet published a report on Thameside. The investigator spoke to the Chair of the IMB, who identified no specific concerns relevant to the investigation. No concerns were raised and the man had not made any applications to the IMB.

19. The man was the first prisoner to die at Thameside since it opened in March 2012.

KEY EVENTS

20. On 11 October 2012, the man was remanded to HMP Thameside charged with drug offences. When he arrived, a nurse carried out a reception health assessment. She noted that he used a salbutamol inhaler to relieve his asthma, had sleep apnoea (abnormal breathing patterns when sleeping), for which he used a special breathing machine at night and used creams for eczema. He was described as 'fit and healthy' on a cell sharing risk assessment.

21. On 16 October, the man attended his first gym session and completed an induction. He signed to confirm that he had been shown how to use the equipment and been made aware of the rules. There was no assessment of his fitness to use the gym.

22. On 18 October, at what appears to be part of a secondary health screen, a nurse took the man's blood pressure and recorded a slightly raised reading of 143/87. No arrangements were made to re-check it.

23. On 21 December, the man attended a nurse's clinic with a swollen ankle. His blood pressure reading that day was 157/105, which is high. The nurse made an appointment for him to see the GP to review his blood pressure and pulse.

24. The man did not attend his GP appointment on 27 December. No reason was recorded. His raised blood pressure was therefore not followed up.

25. Between 16 October and 13 January 2013, the man attended the gym on 22 occasions. He mainly attended cardio sessions but weights and circuits are also listed on his gym record.

The events of the incident

26. One morning in January, the man was on his way from his houseblock to the gym. He was walking with a group of other prisoners. One prisoner said that he seemed his usual self. The prisoner separated from the group to talk to someone else.

27. The man reached a corridor leading to the main gym and was at the foot of some stairs, leading up to the cardio suite, when he collapsed. Two Physical Education Officers (PEOs) heard him fall and were with him within seconds. The prisoner arrived at the gym to find that he had collapsed.

28. PEO 1 radioed for Hotel 1 (The radio call sign for the healthcare first responder). The nurse (who was Hotel 2) responded and said that she was on her way to the gym. The incident log shows that these communications took place between 9.56am and 9.58am.

29. Both PEOs attended to the man. His eyes were open and he was conscious. He tried to stand but PEO 2 asked him to sit with his back against the wall.

He was taking deep breaths and told the PEO that this had not happened before.

30. PEO 3 was in the cardio suite and also heard the noise as the man fell. He went downstairs to help. A Prison Custody Officer (PCO) also came from the sports hall. The duty manager and another PCO also attended.

31. The man's eyes were seen to widen, his head tilted backwards and he lost consciousness. Two PEOs put him in the recovery position. A PCO checked his pulse and reported that it was still strong.

32. The man came round and told PEO 3 that he was asthmatic. The PCO and PEO 3 said in their statements that he told them that he had felt unwell that morning. A nurse had still not arrived. The incident log shows an officer called again for Hotel 1 to attend at 10.02am.

33. The nurse arrived at the gym at approximately 10.10am. The man told her he had last eaten the night before. He said he felt dizzy and unwell and had felt the same a few weeks before when he had not been able to complete his gym work-out. A prisoner told us that the nurse concluded that his blood sugar was low and went to find him a biscuit and this is recorded in the management log. The nurse told the investigator that she did not measure his blood glucose levels but said she had gone to get him some orange juice.

34. Two more nurses arrived at the gym, a little while after the response nurse. The response nurse explained what had happened, that the man was now okay and that she did not need their help, so the two nurses left. There is no record of any clinical observations being taken. The nurse started to help him move back to the houseblock. He stood up, started to walk towards the entrance and collapsed again.

35. At 10.15am, the response nurse said she called Hotel 1 again and the two other nurses came back. There is no record of this call on the incident room log. The timing is slightly at odds with that of subsequent events seen by the investigator on the CCTV footage.

36. The man tried to get to his feet, but said he felt dizzy and was unable to stand. One nurse then took his observations (pulse rate, blood pressure, blood glucose reading, respiratory rate and oxygen saturation rate). The pulse rate was raised and the blood pressure lower than the December reading but the other observations were normal.

37. The response nurse and the third nurse helped the man into a wheelchair. CCTV footage was available from this point and it shows that at 10.14am the nurses took him to the treatment room on the houseblock. (The times shown on the CCTV differ only slightly from the times noted by staff, which could be due to watches and clocks or recollection being slightly different).

38. When they got to the treatment room, one nurse left and the response nurse repeated the man's clinical observations which were within the normal range.

He told the nurses that there was no family history of collapse and he had not experienced this before.

39. One nurse told the investigator that he had tried to call the on-call doctor but there was no response, so he told the Clinical Nurse Lead what had happened that morning. The Clinical Nurse Lead advised that he should be put on observations every 15 to 20 minutes and if “observations dropped” to call an ambulance. The nurse’s statement says that an urgent appointment for him to see the GP was made for the following morning.

40. The man asked to return to his cell as he felt better. The response nurse offered to take him in a wheelchair, but he declined the offer and got up from the bed and left the treatment room. She tried to go with him and locked the treatment room door by which time he had reached E wing door. She ran to open it for him and continued to walk behind him. As he reached the stairs he fell. She told the investigator that she held him and then laid him on the floor. CCTV shows that the time of this third collapse was 10.36am.

41. The nurse says she called for Hotel 1 and she put the man in the recovery position with the help of a prisoner. Two Senior Officers (SOs) also attended. SO 1 said in his statement that the nurse asked for Hotel 1 to be called.

42. The incident log shows that at 10.34am, a PCO radioed for the Hotel call sign to attend E wing. The incident log states that the request was for Hotel 1 to attend D wing uppers. The log goes on to state that Hotel 1 confirmed that he had received the call but, when the control room tried to re-contact him at 10.36am, there was no response. A further call went out at 10.37am for Hotel 2 to acknowledge, but there was no response. This was followed by a request for any Hotel sign to attend D wing lowers. SO 2 contacted the control room at 10.37am to confirm that the location required was E wing lowers.

43. At 10.38am, the control room conducted a test on the general radio network and at 10.39am made another request for Hotel 1 and 2 to attend E wing lowers at which point Hotel 1 confirmed he was there. CCTV shows that, at 10.39am, Hotel 1 arrived at the scene and spoke briefly to SO 2 and the nurse and then left again a minute later (we understand to get some equipment.)

44. Another nurse said that she was informed by an officer that another nurse had requested oxygen so she took some, and an emergency bag, to the wing. CCTV shows her arriving at 10.43am. It took two to three minutes to unravel the oxygen mask and apply it. A nurse left the scene at 10.47am (to get another oxygen cylinder).

45. At 10.49am, CCTV shows the man fighting a nurse’s attempts to apply an oxygen mask to his face. Her statement says she checked his airways, applied oxygen and tried to carry out observations on four occasions but could not get readings.

46. The incident log shows that the control room called for an ambulance at 10.51am after a SO had requested one, but the emergency services informed the control room that an ambulance had already been called. A nurse's statement shows that she called 999 and requested an ambulance at 10.47am, but this is not shown on any of the logs.

.

47. The orderly officer – radio call sign Oscar 1 (the most senior officer responsible for operations) - was briefed about what was happening and at 10.50am he contacted the security supervisor and asked him to prepare a risk assessment and escort pack for him to leave the prison. He identified two officers as an escort if required.

48. The security supervisor asked an officer to complete a risk assessment and other documents. The investigator examined the risk assessment which noted that little information was available on P-NOMIS (the electronic prison record system), but assessed the man as a medium risk. A two person escort was authorised and the form indicated that, as a remand prisoner, double cuffs should be used. Any request for restraints to be removed had to be directed to the duty manager.

49. At 10.53am, CCTV shows that the response nurse attended with a further oxygen cylinder.

50. At 11.01am, Hotel 1 returned to the scene with an emergency bag. Another nurse was attending to the man. Witnesses described his eyes as rolling, that he was short of breath, in a cold sweat and clenching his fists. A SO and two prisoners reported placing him in the recovery position at some point but it is hard to see exactly when this occurred as at times there are many people around him, obscuring the CCTV camera's view

51. At 11.01am, CCTV shows an ambulance and paramedic's vehicle arriving at the main prison building with blue lights flashing. Between 11.01am and 11.03:55am, both vehicles waited in the first sterile area after they had come through the main gate. During this time, the ambulance driver got out and spoke to prison staff. Prison staff are seen to note things down, walk around the vehicle and talk into their radios.

52. At 11.03:55am, both vehicles were waved through to a second area where they had to wait for a further minute before leaving at 11.05am. Three minutes later they appeared on another camera driving along one of the inner-prison roads eventually arriving at the houseblock at 11.08:41am, almost eight minutes after they first arrived at the prison.

53. At 11.05am, a second emergency ambulance arrived. It took ten minutes for this vehicle to arrive at the houseblock.

54. When the paramedics arrived they took over the man's treatment. He was described as "very combative" in the ambulance log and paramedics had difficulty controlling him, who kept pulling off the oxygen mask. At approximately 11.24am, he suffered a cardiac arrest and cardiopulmonary

resuscitation was started (CPR – a mixture of rescue breaths and chest compressions to manually pump oxygen around the body). He was also given adrenaline to stimulate heart activity.

55. At 11.30am, the security supervisor received a call from a PCO informing him that the man was being resuscitated on the wing. He advised that he should not be handcuffed until medical professionals indicated that he was in a stable condition and his life was no longer in danger.

56. The ambulance left the houseblock at 11.58am, the duty manager and a nurse travelled with the man. Handcuffs were not used.

57. The man was taken to hospital in Greenwich arriving at 12.05pm. Hospital staff continued attempts to resuscitate him for some time, but he was pronounced dead at 1.26pm.

Contacting the man's family

58. The prison had some difficulty in finding the man's next of kin details as none had been entered on P-NOMIS or in his core record. Hospital staff repeatedly asked for next of kin information and the escorting officers made a number of calls to the prison to try and establish this.

59. Eventually the prison's family liaison officer obtained the man's brother's telephone number. He called him at 12.20pm to inform him that his brother was gravely ill and that he should go to the hospital. Unfortunately, he did not reach the hospital before he died at 1.26pm, although some of the man's friends got there in time.

60. The next day, the chaplain contacted the man's brother and remained in contact with his family. The Director wrote to him on 15 January, offering his condolences and inviting him to the prison to see where his brother had lived, meet his friends and to return his property. The man's brother and a friend visited the prison on 23 January.

61. During the visit on 23 January, the family met with the prison Governor. He informed them that the man had been on a rowing machine and had been seen to clutch his heart at the time of his death. This was not correct, was contrary to what the family had been told previously and considerably concerned them. PSI 64/2011 makes it clear that accurate information should be given to families.

62. In line with national guidance, the prison offered assistance with the man's funeral expense.

Support for prisoners and staff

63. A notice to all staff and prisoners, informing them of the man's death, was displayed throughout the prison.

64. One of the man's co-accused observed much of what was happening when he collapsed on the wing. A number of other prisoners were also present and involved. A SO raised this with the chaplain as she was very worried about the effect it might have had on the co-accused. The chaplain spoke to him and offered support. Another prisoner, who was involved in helping staff when the man collapsed, was not told directly that he had died, and he was not offered any individual support.

65. The duty manager on the day emailed the Director on the 14 January to tell him that he had spoken to both of the man's co-accused to explain to them what had happened. All prisoners on suicide and self-harm monitoring were checked in case they had been adversely affected by the man's death.

66. The duty Director carried out a debrief on 13 January. All staff involved in the incident attended. The Head of Healthcare was not on duty that day but was kept informed. Staff were informed of the support available to them and encouraged to talk about the incident to those that could offer help.

Post-mortem

67. The post-mortem report gave the cause of death as pulmonary embolism.

ISSUES

Clinical care

68. The clinical reviewer makes a number of recommendations, not all repeated in this report, which the Head of Healthcare will need to consider.

69. Records show that on two occasions the man's blood pressure was recorded as elevated, but no further action was taken. On the 18 October, the response nurse recorded a reading of 143/87, and on 21 December, another nurse recorded 157/105, both of which were high.

70. Although the clinical reviewer has made it clear that the man's pulmonary embolism was not linked to high blood pressure, he says that it is good practice that such readings should be monitored and re-checked. On the first occasion that his blood pressure was high, a GP's appointment was made for him by the nurse. He did not attend that appointment and this was not followed up. On the second occasion, there were no arrangements made for any follow up. The clinical reviewer makes the following recommendation, which we endorse:

    The Head of Healthcare should develop an effective recall system for the monitoring of abnormal blood pressure readings.

Assessment to use the gym

71. The man joined the gym on the 16 October. The gym induction form which he signed indicates that he agreed that he had been made aware of the gym rules, how to operate equipment, the importance of warming up and that he used the gym at his own risk. No questions about his health were included in the document.

72. The investigator asked the gym supervisor whether PAR-Q assessments were completed for prisoners wishing to join the gym. A PAR-Q is a 'Physical Activity Readiness Questionnaire' which helps assess an individual's suitability for exercise. Prison Service Instruction (PSI) 58/2011 states that "PAR-Qs must be completed for all prisoners on PE induction prior to completing any PE activity" and they should be signed by both the prisoner and member of staff.

73. The gym supervisor told the investigator that she had arranged for the PAR-Q assessment to be undertaken by the prison's healthcare department as part of a prisoner's routine secondary health screen. She said that she had personally agreed with the Head of Healthcare what questions should be asked. She gave the investigator a copy of the questions she and the Head of Healthcare had agreed. As far as she was aware, this assessment was in place. However, it remains unclear how gym staff would be made aware of any fitness issues or whether prisoners would sign the document.

74. Records show that on 18 October, the response nurse completed the man's second health screen. The questions asked at the second health screen appointment covered some PAR-Q aspects, such as questions about asthma and diabetes but some very specific questions (mostly relating to physical activity) were missing and there is no evidence that any information was shared with gym staff. We are not satisfied that the prison had introduced an appropriate system to assess prisoners' suitability for using the gym. While this was not linked to the man's death, which could not have been predicted or foreseen, it is important that such assessments are made. We make the following recommendation:

The Director should ensure that prisoners wishing to use the gym complete and sign a PAR-Q as part of their induction in line with PSI 58/2011.

Emergency response

75. The clinical reviewer is concerned that the healthcare response to the man's collapse lacked effective clinical reasoning and decision making. He believes this might have contributed to the failure to call an ambulance after his first and second collapse and to the lack of immediacy on the third. The clinical reviewer considers that an ambulance should have been requested immediately when he first collapsed with acute breathlessness, for which the cause was unknown. It is unacceptable that an ambulance was not called until after he had collapsed three times.

76. The emergency response from healthcare staff appeared confused and was not well managed. Records are poor and much of our evidence and timings is drawn from the CCTV footage. There was only one entry by a nurse on SystmOne (the computerised medical record) about the incident.

77. We are also concerned that the Clinical Nurse Lead, who had not seen the man at that point, did not question the plan to take him back to his cell. He advised that further observations should be taken and an ambulance called if those observations warranted it.

78. The clinical reviewer considers the response by healthcare staff to the man's collapse was poor and for that reason that his care was not equal to that he might have expected in the community. We make the following recommendations:

The Director and Head of Healthcare should ensure that an ambulance is called immediately when a prisoner is in a collapsed state.

The Head of Healthcare should ensure that all healthcare staff are trained and competent to respond to and deal with medical emergencies.

Emergency codes and ambulance access

79. There was poor radio communication about the emergency incident, with a lack of immediate response from healthcare staff and confusion about the location. There was also confusion about when an ambulance was called and delays in allowing ambulances access to the prison.

80. It took the first ambulance and emergency vehicle eight minutes to move across the prison site to attend to the man. It took the second ambulance ten minutes.

81. The ambulance records note that they were subject to a delay on arrival at the prison. We agree that this was the case. At one point, the first ambulance remained stationary just inside the prison gates while prison staff walked around the vehicle making notes.

82. The prison's local protocol says that searches are required when emergency vehicles enter the prison, but that these should be carried out at the scene. The protocol was not agreed with the local ambulance service. It is not clear what was happening during the three minutes that the first ambulance was held in the initial area, what happened during the minute it was held at the second area or where it was for three minutes before it appeared on camera driving to the houseblock, but such delays need to be avoided to provide an effective emergency response.

83. A letter from the Head of Offender Health and Director of the Prison Service sent to all prisons in February 2011 clearly states that the attendance of an ambulance should not be delayed for any reason and required protocols to be agreed with local ambulance services. In addition Prison Service Instruction (PSI) 03/2013, which became effective on 28 February 2013, after the man's death, covers the use of emergency codes and ambulance attendance. The PSI aims to provide guidance to staff on effectively communicating the nature of the emergency; ensuring healthcare staff bring the relevant equipment to treat the emergency and ensuring there is no delay in calling, directing and discharging an ambulance.

84. The use of emergency codes would have clarified the emergency, ensured an ambulance was called without delay and ensured attending staff knew the nature of the emergency they were attending. A protocol agreed with the ambulance service should have ensured there was no delay in ambulances accessing and departing the prison. We make the following recommendation:

    The Director should ensure that local procedures for emergency codes and calling ambulances comply with PSI 03/2013, that all staff are made aware of its requirements and that a protocol is agreed with the ambulance service to ensure that emergency ambulances are not delayed.

Family Liaison

85. The man's next of kin records were not noted on the prison's computer system (P-NOMIS). The prison family liaison officer and other staff had to search through visitor records and phone one of his friends to find out his family contact details. The prison then contacted his brother. The family liaison officer spoke to his brother the day after he died to offer support, but it is not clear that anyone from the prison contacted his family on the day. His family have also told us that when they visited the prison on 23 January, the Governor told them that he had been on a rowing machine and seen to clutch his heart. This was not correct and caused the family considerable concern.

86. We were told that the man's core record was searched for his next of kin details without success. However, during this investigation we found that his mother was noted as his next of kin and her address and telephone number were recorded in his core record.

87. Although this did not cause a significant delay in notifying the family, it is important that a prisoner's up to date next of kin details are clearly recorded on P-NOMIS and accessible to relevant staff. We make the following recommendation:

    The Director should ensure that next of kin records are noted on prisoners' P-NOMIS record and accessible to relevant staff when required.

Support for prisoners

88. A notice announcing the man's death was displayed on the prison's Custodial Management System (the prison also advertises the Samaritan's telephone number and has Listeners – prisoners selected and trained by the Samaritans to offer emotional support to fellow prisoners). In addition, his co-accused were spoken to and offered support. However, one prisoner, who was very involved during the man's final collapse, including assisting staff to put him in the recovery position, was not offered any individual support. He told us that he only learnt what happened from another prisoner and that no member of staff spoke to him or asked how he was.

89. It is important that everyone involved in an emergency incident, particularly one resulting in death, is offered appropriate support to ensure their wellbeing. We make the following recommendation:

    The Director should ensure that everyone involved in a traumatic emergency incident is offered appropriate support.

RECOMMENDATIONS

1. The Head of Healthcare should develop an effective recall system for the monitoring of abnormal blood pressure readings.

2. The Director should ensure that prisoners wishing to use the gym complete and sign a PAR-Q as part of their induction in line with PSI 58/2011.

3. The Director and Head of Healthcare should ensure that an ambulance is called immediately when a prisoner is in a collapsed state.

4. The Head of Healthcare should ensure that all healthcare staff are trained and competent to respond to and deal with medical emergencies.

5. The Director should ensure that local procedures for emergency codes and calling ambulances comply with PSI 03/2013 that all staff are made aware of its requirements and that a protocol is agreed with the ambulance service to ensure that emergency ambulances are not delayed.

6. The Director should ensure that next of kin records are noted on the prisoners P-NOMIS record and accessible to relevant staff when required.

7. The Director should ensure that everyone involved in a traumatic emergency incident is offered appropriate support.

ACTION PLAN: The Man – HMP Thameside

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should develop an effective recall system for the monitoring of abnormal blood pressure readings.	Accepted	Nurses will clearly document in the clinical records the action taken following observations and high blood pressure recorded. The Head of Healthcare will ensure that spot checks are undertaken in order to ensure compliance. Follow-up appointments following abnormal blood pressure readings will be offered and prisoners will be encouraged to attend.	Completed and ongoing.	
2	The Director should ensure that prisoners wishing to use the gym complete and sign a PAR-Q as part of their induction in line with PSI 58/2011.	Accepted	The gym induction process now follows all elements of Prison Service Instruction (PSI) 58/2011 – *Physical Education for Prisoners*. A Physical Activity Readiness Questionnaire (PAR-Q) is now completed before any prisoner is permitted to use the gym. The gym supervisor checks inductions are completed properly.	Completed and ongoing.	
3	The Director and Head of Healthcare should ensure that an ambulance is called immediately when a prisoner is in a collapsed state.	Accepted	Thameside's procedure now complies with PSI 03/2013 – *Medical Emergency Response Code.* An ambulance is called immediately when a prisoner is found unconscious.	Completed and ongoing.	
4	The Head of Healthcare should ensure that all healthcare staff are trained and competent to respond to and deal with medical emergencies.	Accepted	As part of on-going nurse training and personal development portfolios, there is a requirement to have annual intermediate life support (ILS) updates. However, it is recognised that despite nurses undertaking annual ILS, further development and training is needed for emergency responders attending situations	30 November 2013	

			within a custodial environment. Emergency responders will be further supported by use of scenarios and desk-top exercises. The Head of Healthcare will arrange this.		
5	The Director should ensure that local procedures for emergency codes and calling ambulances comply with PSI 03/2013 and that all staff are made aware of its requirements and that a protocol is agreed with the ambulance service to ensure that emergency ambulances are not delayed.	Accepted	The prison has adopted the Code Red/Code Blue protocol outlined in PSI 03/2013. This was agreed and referenced in the minutes of the safer custody meeting in April 2013. All operational staff have been briefed on the appropriate use of emergency codes following this agreement. Staff have also been briefed on the procedure to be adopted for ambulances, to expedite entry and exit from the prison consistent with maintaining security. This process will be fully documented by 30 September 2013. A protocol will be developed around this procedure and offered to the London Ambulance Service for agreement, with expected completion (i.e. agreement signed by both parties) by 31 December 2013. The security manager is responsible for this action.	31 December 2013.	
6	The Director should ensure that next of kin records are noted on the prisoners P-NOMIS record and accessible to relevant staff when required.	Accepted	All prisoner Prison-NOMIS records have been updated to include next of kin details where these have been provided by the prisoner. This is now occurring on reception to ensure records remain up-to-date. Compliance is checked by the reception manager through the Prison-NOMIS reporting function. All staff who may need to access this data have access to Prison-NOMIS.	Completed and ongoing.	
7	The Director should ensure that everyone involved in a traumatic emergency	Accepted	The duty manager will be responsible for ensuring that support is offered immediately following a traumatic emergency incident.	Completed and ongoing.	

	incident is offered appropriate support.		Contingency plans include mobilisation of the staff care team, which includes the Chaplaincy team. Ongoing support will be provided by the staff care team who will monitor and support staff in consultation with their line manager. The Chaplaincy team will support prisoners in consultation with the relevant wing senior officer, personal officer and safer custody team.		