Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Andrew Dean, a prisoner at HMP/YOI Lewes, on 26 March 2021

A report by the Prisons and Probation Ombudsman

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Our vision

To carry out independent investigations to make custody and community supervision safer and fairer

Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Andrew Dean was found hanged in his cell at HMP Lewes on 26 March 2021. He was 50 years old. I offer my condolences to his family and friends.

Mr Dean was only at Lewes for two days when he took his life. During his short time in prison, Mr Dean presented as untroubled, sought minimal support from staff and revealed nothing to suggest his intentions. I am satisfied that prison staff could not reasonably have foreseen or prevented Mr Dean's death.

However, we have identified some healthcare concerns. Although these did not affect the outcome for Mr Dean, we consider that they could make a difference in other cases if they are not adequately addressed.

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

Sue McAllister CB
Prisons and Probation Ombudsman **February 2022**

Contents

Summary

Events

1. On 24 March 2021, Mr Andrew Dean was recalled on licence and remanded to HMP Lewes. He was serving a life sentence for murder and had been released from prison in 2007.

2. When Mr Dean arrived at Lewes, staff assessed that he was not at risk of suicide or self-harm. Although he refused to complete his initial health screen in Reception, he assured staff that he was fine. Mr Dean tried to telephone his partner when he arrived but was not able to speak to her.

3. Mr Dean had to isolate for 14 days under the COVID-19 requirements. He shared a cell with his co-defendant and longstanding friend.

4. On the morning of 26 March, Mr Dean's cellmate left their cell to take a shower, leaving Mr Dean alone. On his return, Mr Dean's cellmate saw that something was wrong and the toilet door in their cell was shut. He alerted staff who responded and found Mr Dean hanging behind the toilet door. An officer radioed a medical emergency code blue and staff responded quickly. Staff tried to resuscitate Mr Dean until paramedics arrived and took over. They were unable to resuscitate Mr Dean and pronounced that he had died.

Findings

5. We are satisfied that prison staff reviewed Mr Dean's risk information, appropriately assessed his risk of suicide and self-harm when he arrived at Lewes, and that they could not reasonably have foreseen or prevented his death.

6. While we recognise the difficulties prison staff have faced during the COVID-19 pandemic, we consider that more should have been done to facilitate telephone access for Mr Dean in his early days in custody and until he had access to the PIN phone system.

7. The clinical reviewer concluded that the clinical care that Mr Dean received at Lewes was of a reasonable standard and at least equivalent to that which he could have expected to receive in the community.

8. However, we share the clinical reviewer's concern that healthcare staff were not keeping accurate medical records.

9. We are also concerned that there was confusion over the response to the medical emergency code.

10. The clinical reviewer did not consider that these failings affected the outcome for Mr Dean, but we are concerned that they could make a critical difference in future cases.

Recommendations

- The Governor should share this report with Officer A and arrange for a senior manager to discuss the Ombudsman's findings with him.

- The Governor should ensure that newly arrived prisoners have the opportunity to make telephone calls if there is a delay in them accessing their telephone account, and that staff understand the importance of this in relation to safer custody.

- The Head of Healthcare should ensure that healthcare staff are trained as a matter of urgency to keep accurate healthcare records.

- The Head of Healthcare should:

    - ensure that the changes made to reception screening processes are reviewed to check that they have resulted in the required improvement; and

    - should write to the Ombudsman to confirm this.

- The Head of Healthcare should share this report with Nurse A and the pharmacy technician and discuss the Ombudsman's findings with them.

- The Governor should satisfy herself that there are appropriate procedures in place to ensure that healthcare staff respond immediately to medical emergency codes.

- The Head of Healthcare should request evidence from all agency staff, including those currently employed at Lewes, that their resuscitation training is up to date and should ensure that this is recorded.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Lewes informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

12. The investigator obtained copies of relevant extracts from Mr Dean's prison and medical records.

13. NHS England commissioned a clinical reviewer to review Mr Dean's clinical care at the prison.

14. The investigator interviewed ten members of staff and one prisoner at Lewes, most jointly with the clinical reviewer. The interviews were completed by video and telephone because of the restrictions imposed due to the COVID-19 pandemic.

15. We informed HM Coroner for East Sussex of the investigation. The Coroner gave us Mr Dean's cause of death. We have given the Coroner a copy of this report.

16. We contacted Mr Dean's sister and partner to explain the investigation. They wanted to know what happened leading up to Mr Dean's death. Mr Dean's sister told us that Mr Dean had a bad back and was taking strong opiate medication. She was concerned that by the time he died, he would have been in pain and having medication withdrawal symptoms. We have tried to address her concerns in this report as well as in separate correspondence.

17. Mr Dean's sister and partner received a copy of the initial report. His partner pointed out one factual inaccuracy. This report has been amended accordingly. Mr Dean's partner also raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). They identified one factual inaccuracy that has been amended in the report. All recommendations were accepted.

Background Information

HMP Lewes

19. HMP Lewes is a local prison serving the courts of East and West Sussex and holds up to 692 men. Sussex Partnership NHS Foundation Trust provides primary care services. Healthcare is provided on a 24-hour basis. The prison has a healthcare centre with a full-time senior medical officer. There is a 12-bed inpatient unit, an outpatient facility, a pharmacy and a range of clinics.

HM Inspectorate of Prisons (HMIP)

20. The most recent inspection of HMP Lewes was in January 2019. Inspectors noted that the inspection findings were deeply troubling and indicative of systemic failure. They concluded that the prison's performance for safety was heading towards the lowest possible assessment rating. Inspectors also noted that there had been five self-inflicted deaths in the three years since their previous inspection, and that most of the Prisons and Probation Ombudsman's recommendations had not been satisfactorily implemented.

21. HMIP conducted an independent review of progress at Lewes in December 2019. Inspectors concluded that, overall, the review was promising, and that the Governor and her senior managers were taking the prison in the right direction. They considered that the prison had made reasonable progress to address the recommendations to prevent self-harm. The number of self-harm incidents had declined by over a third in the previous six months, and there had been one self-inflicted death since the inspection. Managers had analysed local self-harm data and written a comprehensive self-harm prevention strategy. Plans were in place to implement the new strategy early in 2020.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest published annual report for the year to January 2021, the IMB reported that every aspect of prisoners' life at Lewes had been affected by COVID-19 restrictions, overwhelmingly to their detriment. These included fewer opportunities for education or work and the long-term psychological impact of being locked in a cell for up to 23.5 hours a day.

Previous deaths at HMP Lewes

23. Mr Dean was the third prisoner to take his own life at Lewes since February 2019. Our investigation into the previous self-inflicted death in January 2021 found that, despite a number of clear risk factors, staff did not start suicide and self-harm prevention measures. There has been one self-inflicted death since Mr Dean's death, which we are still investigating.

Key Events

Arrival at HMP Lewes

24. On 24 March 2021, Mr Andrew Dean was recalled on licence, and remanded to HMP Lewes, charged with drug-related offences. He had been serving a life sentence for murder and had been released from prison on licence in 2007.

25. The Person Escort Record (PER), which accompanied Mr Dean to Lewes, noted that he had no history of attempted suicide or self-harm, no alcohol or drugs problems and was not taking any prescribed medication. The police custody officer recorded that Mr Dean had refused to answer questions about his health.

26. Officer A completed Mr Dean's reception and first night interview when he arrived at Lewes. The interview included questions about drug addiction and thoughts of suicide and self-harm. Mr Dean said he had no problems but felt a little nervous as it had been a long time since he was last in prison. The officer told us that as an experienced suicide and self-harm prevention (ACCT) assessor, he was familiar with recognising signs from prisoners' speech and body language that could identify a concern. He said he had no concerns about Mr Dean. He explained the prison rules and regime to him. Mr Dean said he wanted to make a phone call once he was located on A Wing, the first night centre.

27. Staff told us that when Mr Dean arrived at Lewes, planned IT work was affecting internet access and the ability to access some prison records and to record new data on NOMIS (prisoners' electronic records). As a result, staff entered Mr Dean's details on NOMIS the following morning.

28. Nurse A told us that she tried to conduct Mr Dean's initial healthcare screen, but when she went to collect him from the Reception holding room, he refused to accompany her to be interviewed for his healthcare assessment. Mr Dean told her that he felt fine, had no thoughts of suicide or self-harm, and did not need to be assessed. She said that she had seen Mr Dean interacting with other prisoners in the holding room.

29. Due to COVID-19 restrictions, Mr Dean was required to live on A Wing, which was used as a Reverse Cohorting Unit, for 14 days after arrival. At that time, prisoners were being locked in their cells for 23 hours a day.

30. The investigator was told that prison records showed Mr Dean had made two phone calls to his girlfriend at 8.02pm and 8.10pm from the first night centre PIN Phone account. Both calls lasted five seconds. He did not make contact with her and he left no message.

31. Mr Dean arrived at Lewes with his long-time friend and co-defendant. They were paired together to share a cell on A Wing. His friend said the television in their cell was not working. He said he was aware that Mr Dean had tried unsuccessfully to contact his partner by phone.

25 March

32. Mr Dean's friend told us that on the morning of 25 March, Mr Dean had rung his cell bell and asked an unknown officer if he could make a phone call. Prison cell bell records show that this occurred at 8.27am. An officer responded and said he would sort it out for Mr Dean later. However, the officer never returned. The friend said that when their cell was opened that morning, Mr Dean again asked an officer if he could make a phone call, but this was not granted. He said Mr Dean was frustrated as he had not been able to tell his family that he had been arrested. He also said that Mr Dean was concerned that he would have to spend a long period in custody because of his life sentence status.

33. Nurse A told us that she phoned A Wing and asked an unknown officer to ask Mr Dean if he was willing to attend his initial health screen. Mr Dean apparently again declined.

34. That morning, a member of the chaplaincy visited Mr Dean's cell as part of his and his friend's induction. Mr Dean raised no concerns.

35. At 1.17pm, a pharmacy technician completed a medication reconciliation to determine if Mr Dean was prescribed any medications in the community. She recorded details of this in Mr Dean's electronic medical record (SystmOne). She recorded that she had spoken to Mr Dean and had access to his summary care record (SCR, an electronic record of important patient information, created from community GP medical records). Some of her recorded responses to a number of questions were inaccurate:

> "Is this the patient's first time in a secure setting? **Yes**
>
> Has the patient had a change in their custodial status e.g. licence recall? **No**
>
> Has the patient had other recent life changing event? **No"**

36. At interview, the pharmacy technician told us that she had not in fact met or spoken to Mr Dean and had provided the responses to the questions herself based on his medical and prison records. When asked why she had recorded that she had spoken to Mr Dean, she said that healthcare management required her to have two sources of information.

37. Nurse A had seen Mr Dean briefly the previous day but did not record her contact with him until 2.46pm on 25 March. She told us that there was a delay in accessing Mr Dean's medical records when he arrived. This was because, while at court, he was due to be transferred to HMP Elmley and as a result, only healthcare staff at Elmley were able to access his medical records. She said that she had tried to phone Elmley to rectify this but there was no response.

38. Nurse A recorded that Mr Dean had declined to be interviewed and that she completed the assessment in his absence. She recorded information about Mr Dean's physical and mental health and answered questions in the electronic medical record template used for completing the reception screen. Some of the answers to these questions could only have been obtained if Mr Dean had engaged with the assessment. For example, where specific information was required (such as Mr Dean's height and weight), she estimated the answers to these questions. Where detailed and honest answers were required (for example, whether Mr Dean

was taking any medication, had used drugs, had recently seen a doctor and whether he had any history of suicide or self-harm in prison), she responded "no" or entered text to suggest that she had no concerns about Mr Dean.

39. Nurse A told us that the medical record template required certain information to be recorded and would not allow other information to be added without it. She said she therefore had to estimate and use her judgement to answer the template questions. She also told us that she had been told by management to give answers that she thought were most appropriate for questions that a prisoner did not answer.

40. Prison records show that the cell bell for Mr Dean's cell was pressed at 4.00pm and 4.55pm. Staff responded on both occasions. No other information was recorded.

41. That evening and night, prison staff raised no concerns about Mr Dean. When Mr Dean and his friend were checked at around 10.00pm, they told the night duty officer that their television was not working.

26 March

42. CCTV footage shows that at 9.55am on the morning of 26 March, Officer B unlocked Mr Dean's cell. She told us that Mr Dean was sitting on his bed. His friend left the cell at 9.56am to take a shower. He said he had no concerns about Mr Dean at the time. CCTV shows that he returned to the cell at 10.11am and left again a minute later and walked down the wing landing.

43. Officer C told us that Mr Dean's friend approached him and said that something was wrong in his cell and needed his immediate attention. The officer said that he knew from his face that something was wrong. He asked Officer B, who was nearby, to accompany him to the cell.

44. CCTV footage shows that at 10.13am, both officers entered Mr Dean's cell. Officer B noted the toilet door was ajar, with a piece of knotted material at the hinge and a pair of trainers wedged under the door. When she pulled the toilet door, Mr Dean was hanging low on the door frame, with a ligature around his neck, and fell to the floor. He looked pale and his lips were tinged blue. Officer C used his fish-knife to cut the ligature from Mr Dean's neck. Mr Dean showed no signs of life.

45. Officer B shouted for help and called a medical emergency code blue, indicating a life-threatening situation. The control room log recorded that this occurred at 10.14am and that they called an ambulance.

46. Both officers laid Mr Dean flat on the floor and checked him for signs of life. Within 20 seconds, two officers arrived at Mr Dean's cell in response to the emergency code, followed by a Supervising Officer (SO). One officer quickly started cardiopulmonary resuscitation (CPR) and noted Mr Dean's face was blue and cold. Officer C took over CPR.

47. In her statement, an officer said that she had heard the code blue. The communications officer had also called a healthcare code blue at least twice, indicating that an emergency healthcare response nurse was required. However, healthcare staff had not responded to the call. As she was close to the healthcare unit, she ran to the nurses' station to alert them. When she arrived, she saw two nurses working on their computers. She said she asked Nurse B (who was the

designated emergency responder) to attend the emergency code blue on A Wing. She said Nurse B looked shocked but quickly made his way to A Wing, accompanied by Nurse C.

48. At 10.16am, both nurses, arrived at Mr Dean's cell with the emergency medical bags. Nurse C took over chest compressions while Nurse B set up the defibrillator, which advised no shock, and that CPR should continue. At 10.17am, another nurse arrived and set up additional medical equipment.

49. An officer reported that one of the nursing team was providing chest compressions incorrectly. Nurse B also told us that an officer had commented that Nurse C was not delivering chest compressions correctly during the resuscitation efforts.

50. Healthcare and prison staff continued CPR until paramedics arrived at 10.25am and took over. At 10.27am, the paramedics took Mr Dean onto the wing landing for better access. Advanced resuscitation continued. At 11.27am, the paramedics ceased resuscitation attempts and pronounced Mr Dean's death.

Contact with Mr Dean's family

51. After Mr Dean died, staff identified that he had listed his partner as his next of kin. Two officers were appointed as the prison's family liaison officers. Due to the COVID-19 restrictions in place, one of the officers phoned Mr Dean's partner at 1.20pm and broke the news of Mr Dean's death. Mr Dean's sister was present, and she continued to liaise with the prison about her brother's death.

52. The prison provided ongoing support and contributed towards the costs of Mr Dean's funeral in line with national instructions.

Support for prisoners and staff

53. After Mr Dean's death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. The prison posted notices informing other prisoners of Mr Dean's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Dean's death.

Post-mortem report

54. The post-mortem report concluded that Mr Dean died from hanging. No illicit substances were detected in his system.

Findings

Identifying risk of suicide and self-harm

55. Prison Service Instruction (PSI) 64/2011 on safer custody sets out the risk factors and triggers that might increase a prisoner's risk of suicide and self-harm and the procedures (known as ACCT) that staff must follow when they identify a prisoner at risk.

56. Mr Dean had a significant risk factor in that he had been recalled to prison after 14 years. However, he gave staff no indication that he was distressed, he had no history of attempted suicide or self-harm, no substance misuse issues or known health concerns. Reception staff said that Mr Dean was calm and displayed no overt distress. Although Mr Dean refused his initial health screen interview, neither prison nor healthcare staff were concerned about his mental health and he denied thoughts of suicide or self-harm. In the day and a half that Mr Dean was at Lewes, staff assessed that he was not at risk of suicide and self-harm, and we consider that it was reasonable that they did not start ACCT procedures during this very short period.

57. We are, however, concerned that Officer A, who told us he was an experienced ACCT assessor, said that he could identify if a prisoner was at risk of suicide or self-harm from his speech and body language, and did not mention Mr Dean's recall as a risk factor. We have said repeatedly over many years that staff must take a prisoner's risk factors into account when assessing risk and not focus solely on what they say or how they present, and it is worrying that an experienced ACCT assessor is apparently not aware of this. We recommend:

    The Governor should share this report with Officer A and arrange for a senior manager to discuss the Ombudsman's findings with him.

58. There are indications that Mr Dean had planned in advance to take his life. He left three suicide notes and he appears to have taken his life as soon as his cellmate left for a shower - his cellmate was only gone for 15 minutes but Mr Dean had no signs of life and was cold when he was found. However, Mr Dean's cellmate was a longstanding friend, and although he was aware that Mr Dean was unhappy about his return to prison, Mr Dean had not told him of his intentions, and he had not detected any signs of Mr Dean's plans to take his life.

59. We do not therefore consider that prison staff could reasonably have predicted that Mr Dean was at imminent risk of suicide.

Communications with family and access to telephones

60. PSI 49/2011 on prisoner communication services requires prisons to encourage prisoners to maintain contacts in the community and meaningful family ties.

61. Mr Dean was recalled to prison on a Wednesday evening. As administration of the PIN phone accounts system in prisons usually takes at least a few days to set up, he would not have been able to access the system until at least the following week. As part of the reception interview process, Mr Dean was offered a routine short telephone call but two attempts to contact his partner were unsuccessful. The next

day, Mr Dean's cellmate said that Mr Dean asked staff on more than one occasion to use the phone again to contact his partner. However, no one followed up on his requests and no one recorded his requests.

62. Mr Dean was new to the prison and had not yet been given access to the PIN phone system. He was, therefore, reliant on the kindness of staff, subject to any resource and security issues, to facilitate a phone call for him. After Mr Dean had tried unsuccessfully to contact his partner, we found no evidence that any arrangement was put in place to help him try to contact his partner again.

63. The change of circumstances for Mr Dean was very significant. He had been recalled to prison after 14 years to a prison cell where he had very basic amenities and none of his possessions. The prison was also subject to COVID-19 restrictions, with all prisoners subject to a very limited regime and time out of cell. In such restricted circumstances, telephone contact with the outside world is likely to be all the more important, especially when a prisoner first arrives in custody. While we recognise the significant challenges that prison staff have faced during the COVID-19 pandemic, we consider that more could have been done to support Mr Dean's situation and facilitate telephone access. We make the following recommendation:

The Governor should ensure that newly arrived prisoners have the opportunity to make telephone calls if there is a delay in them accessing their telephone account and that staff understand the importance of this in relation to safer custody.

Clinical care

64. The clinical reviewer concluded that overall, the healthcare that Mr Dean received at Lewes was of a reasonable standard and was equivalent to that which he could have expected to receive in the wider community.

65. The clinical reviewer noted that Mr Dean did not declare any physical or mental health conditions and that no conditions or prescribed medications were identified by the medicine reconciliation process. He said that if Mr Dean was receiving prescribed medication for back pain, the review of his SCR would have identified this – but it did not. He noted that this does not exclude the possibility that Mr Dean was taking opiate drugs that were not prescribed, but, if he was, he did not tell anyone this.

66. However, the clinical reviewer was concerned about Mr Dean's reception screen and the recording of clinical notes.

Reception health screen and medicine reconciliation records

67. Nurse A told us that it was not uncommon for prisoners to decline a healthcare screen when they arrived at prison. She said that when this happened, she usually went through the prisoner's medical notes to check if there were any alerts. However, she said that she had been unable to check Mr Dean's medical records as they were locked at Elmley and she was unable to get a reply from them when she phoned. There was also no access to NOMIS records that night as the computer systems were not working.

68. During our investigation, it was clear that Nurse A and the pharmacy technician had invented some of their recorded medical entries and provided answers to questions that could not have been verified without Mr Dean's cooperation, which we know was not forthcoming. Both members of staff had used templates on the SystmOne record to record their answers. While templates can be extremely useful as an aide memoire for recording information, they can prompt a clinician to record an answer that has not been given.

69. Nurse A and the pharmacy technician told us that healthcare managers had instructed them to complete templates in such a way that they felt compelled to give unverified information. The Head of Healthcare told us that the normal expectation was for two sources of information to be used to complete the templates.

70. The clinical reviewer said that if information is not available, whether because the prisoner has refused to provide it or otherwise, the clinician should not record a response, but should justify the exclusion with a statement of fact. He said that he did not believe that healthcare management expected staff to falsify records. He thought it was likely that this was the result of a lack of training and the absence of a clear protocol, particularly for prisoners who refused to comply with screening.

71. We are extremely concerned that two members of the healthcare team entered unverified and incorrect information in Mr Dean's medical records, and appeared to suggest that this was normal practice known to, if not encouraged by, healthcare managers. It is essential that healthcare staff understand that if health records are not accurate, they are not only worthless, but potentially unsafe.

72. The Head of Healthcare told us that these concerns had been identified in their internal review after Mr Dean's death. She said that a number of changes had been implemented, including:

- reception nurses have been told that, if a prisoner declines an initial health screen or the electronic medical records are not available, they should consider increasing observations on the First Night Centre or starting ACCT procedures;
- the reception nurse who has contact with prisoners, rather than the pharmacy technician, should perform the medicine reconciliation;
- reception nurses should receive training in how to complete health screens;
- the prison should use employed clinicians in reception rather than agency staff; and
- there need to be improved standards in recording accurate information in reception screen records.

73. We are concerned that some of these points are aspirations, rather than implemented changes. We make the following recommendations:

The Head of Healthcare should ensure that healthcare staff are trained as a matter of urgency to keep accurate healthcare records.

The Head of Healthcare should:

- **ensure that the changes made to reception screening processes are reviewed to check that they have resulted in the required improvement; and**

- **should write to the Ombudsman to confirm this.**

The Head of Healthcare should share this report with Nurse A and the pharmacy technician and discuss the Ombudsman's findings with them.

The emergency response

74. A prison officer raised concerns that healthcare staff had not responded quickly enough when the code blue was called.

75. Certain members of the healthcare team carry communication radios and are allocated a radio call sign. We were told that the communications room had incorrectly sent the code blue response call to the non-emergency responder. A general communication call was also sent out and this resulted in a prison officer alerting the emergency responder to the code blue call. We were told that there was no significant delay in his response and the record shows that he arrived on the scene within two minutes, and shortly before the non-emergency responder.

76. The Head of Healthcare told us that she had reviewed this issue after Mr Dean's death and had issued a notice to the communications room staff to learn from this mistake.

77. We remain very concerned about the confusion. It is essential that the appropriate healthcare staff are alerted and respond immediately to medical emergency codes. A prison officer should not have to go and fetch them. We recommend:

The Governor should satisfy herself that there are appropriate procedures in place to ensure that healthcare staff respond immediately to medical emergency codes.

Cardiopulmonary resuscitation

78. A prison officer was concerned about the effectiveness of the chest compressions that an agency nurse, Nurse C, administered.

79. Nurse C told us at interview that his resuscitation training was up to date. The Head of Healthcare told us that life support training was provided for employed healthcare staff, and that agency staff were expected to ensure their training was up to date. She said it was now the practice for Lewes to request evidence of this.

80. The clinical reviewer noted that it was unlikely that the initial ineffectiveness of Nurse C's chest compressions made any difference to the resuscitation outcome. Nevertheless, we recommend:

The Head of Healthcare should request evidence from all agency staff, including those currently employed at Lewes, that their resuscitation training is up to date and should ensure that this is recorded.

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