Investigation into the circumstances surrounding the death of a man in custody of HMP Wormwood Scrubs, in September 2008

Report by the Prisons and Probation Ombudsman for England and Wales

June 2009

This is a report into the death of a man at HMP Wormwood Scrubs in September 2008. The post mortem showed that he died of a heart attack. He had been in custody on remand for just one month, and it was his first time in prison. .

I offer my sincere condolences to his family for their loss. One of my Family Liaison Officers, liaised with the man's parents throughout the investigation process.

The investigation was led by my one of my investigators. I must thank the local Primary Care Trust for appointing the clinical reviewer. I am also grateful to the Governor and staff of HMP Wormwood Scrubs, especially the liaison officer, whose assistance was greatly appreciated by my colleague.

As with all deaths from natural causes, the findings of the clinical review play critical part in my report. The reviewer, judges that the man should have received greater care whilst at HMP Wormwood Scrubs. I am particularly concerned about the emergency procedures.

I make ten recommendations concerning emergency response and first on scene protocol, chest pain protocol, cardio pulmonary resuscitation (CPR) training, the level of nursing cover, the standard of record keeping and the protocol following a death in custody. I am disappointed to have to repeat recommendations about matters upon which I have previously reported at Wormwood Scrubs

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.

Stephen Shaw CBE
Prisons and Probation Ombudsman **June 2009**

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SUMMARY

At the time of his death in September 2008, the man was on remand and had been at HMP Wormwood Scrubs since 20 August. He was next due in court in September.

On arrival at Wormwood Scrubs, the man had an initial first health screen assessment. It confirmed that he was on prescribed medication for depression and anxiety: Mirtazapine (an antidepressant) and Quetiapine (an antipsychotic). The man said that he had seen his doctor recently for a cholesterol count. He also said he was a smoker but did not use drugs.

The man was seen by the Mental Health Inreach Team in August. He said he was not anxious and had no thoughts of suicide. In September, he was seen in Healthcare because he had complained of chest pain but he refused to go to the local hospital. However, his blood pressure was taken and an electrocardiograph (to identify abnormal heart rhythms) was undertaken. The results of these tests were recorded as normal. He was assessed as being fit for light exercise and employment as a painter.

A week later the man was seen again in Healthcare because he was passing blood in his stool. A referral was made to the Gastroenterology Department at the local hospital for further tests. He was seen by the doctor on 11 September because he felt agitated. As a result his medication was increased just for that day. He spoke to his parents on the telephone the following day and told them that he had not yet been for his hospital appointment.

At approximately 8.00pm on Sunday, the man's cell mate, rang the cell bell as he had heard him making strange noises. The first officer answered the cell bell and was told by the cell mate that the man was having problems breathing. The officer saw the man lying on his bed. The officer went to the office and telephoned the control room to ask for the assistance of a nurse. The call was not transmitted as an emergency.

The second nurse found that the man was unconscious and not breathing. The officer and the nurse, with the assistance of the cell mate, moved him on to the cell floor. The nurse began cardio pulmonary resuscitation (CPR). Other officers soon arrived and assisted with CPR.

The call was made for an ambulance with the detail given that there had been a suicide attempt by hanging. Whilst this information was wholly inaccurate, it was not critical and did ensure that the 999 call was made.

The first paramedic arrived at Wormwood Scrubs when CPR was being delivered by prison staff. The paramedic raised concerns over the effectiveness of the airway management technique being undertaken. The ambulance crew arrived at Wormwood Scrubs 15 minutes later and assessed that the man had died. He was pronounced dead by a doctor at 9.08pm. The post mortem shows that the cause of death was a heart attack.

There are several key issues arising out of this investigation. According to the clinical reviewer, the care that the man received was not equivalent to that expected in the community. Nor were medical records maintained to the required standard. There is also concern about the emergency response and chest pain protocol.

Wormwood Scrubs has also not followed the protocol outlined in Prison Service Order 2710, Follow up to deaths in custody, in respect of family liaison and holding a debrief for staff after a death has occurred.

THE INVESTIGATION PROCESS

1. One of my investigator, visited Wormwood Scrubs and spoke to staff who knew the man. My investigator interviewed four members of staff and one prisoner. Notices were posted to staff and prisoners about the investigation inviting contributions, but no one came forward as a result. In addition, my investigator studied all relevant prison records relating to the man. They included his main prison record, medical records and statements made by staff. My investigator also saw inside the man's cell.

2. The local Primary Care Trust carried out a review of the man's clinical care. I am grateful to the clinical reviewer for undertaking this review which was delivered in accordance with my timescales. My investigator discussed aspects of the man's treatment with both healthcare staff at Wormwood Scrubs and with the clinical reviewer.

3. My investigator liaised with London Ambulance Service to obtain information from their patient record about the CPR techniques being used by staff at Wormwood Scrubs.

4. As part of the investigation, my investigator attempted to interview the first nurse. The nurse supplied by Mayday Nursing Healthcare PLC.) Despite several attempts made through the agency, no contact has been made and no interview has taken place.

5. My investigator contacted Her Majesty's Coroner for North London, to inform them of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, my report will be sent to HM Coroner to assist in her enquiries into the man's death.

6. One of my family liaison officers, was in contact with the man's parents throughout the investigation. His parents raised concerns about the level of healthcare he received, in particular his treatment for high cholesterol and changes to his medication for depression. They were concerned about what caused his high blood pressure and whether the change in his medication was a contributing factor. They wished to find out why his hospital appointment in September had been cancelled and the reason given for the delay. His mother had spoken to him in September. She was concerned as to what treatment he received as he had told her he was suffering from chest pains. The man's parents were deeply concerned and frustrated that there was no point of contact and no one to speak to at the prison regarding their concerns about their son's health.

HMP WORMWOOD SCRUBS

7. Wormwood Scrubs is a local prison that accepts all suitable male prisoners over the age of 21 from the courts in its catchment area. The establishment has five main wings and a number of smaller dedicated units. A and B wings manage both remand and sentenced prisoners. C wing manages prisoners on the Intensive Drug Treatment System that offers enhanced support for offenders with substance misuse problems.

8. Her Majesty's Chief Inspector of Prisons, conducted a full unannounced inspection of Wormwood Scrubs between 9 and 13 June 2008. The report of the inspection includes the following comments:

   "Wormwood Scrubs, like many other large local prisons, operated under considerable pressure. It was taking in around 300 prisoners a week, and over the previous 12 days had received 240 men new to the prison, often arriving late. Shortage of staff created further pressure.

   "Health services were on special measures as part of a primary care trust improvement plan. There had been recent investment in the services, including a major training programme for staff, but no recent health needs assessment. Clinical governance arrangements were improving, but policies were not up to date and clinical records were poorly stored.

   "One in five hospital appointments had been cancelled in the previous two months because of lack of staff escorts; this included some cancelled at least twice. We were not confident that prisoners' clinical needs were considered when appointments were cancelled.

   "Clinical records were stored on unsuitable filing racks. Although there was a tracer system, we failed to locate several sets of notes. This appeared to contradict the NHS Code of Practice for records management.

   "The wing treatment rooms were staffed throughout the core day and evening. Staff operated an open door policy, and we observed some good interactions between health professionals and prisoners. There were no policies to ensure the efficient sharing of relevant health and social care information."

9. There are three nurses on duty during the night. One nurse is dedicated to the healthcare unit, another is dedicated to the substance misuse unit, and the final nurse provides cover for the remainder of the prison population.

10. As part of the Local Suicide Prevention Strategy, Wormwood Scrubs has a Safer Custody Hotline. This is a dedicated telephone line for prisoners' family and friends to share any concerns they may have about an individual's wellbeing whilst in custody. Family and friends may also write to the prison. This service is publicised in the Visitors Centre, Visits Hall, and in other areas of the establishment.

11. All contacts to the Safer Custody Hotline by telephone, or more generally to the prison by mail, are recorded in the contacts diary. It details the name and number of the prisoner, the date and time the contact was received, and the reason for the contact. The record shows what action was taken immediately, what referrals, if any, were made, and what follow up action was taken.

12. The prison's Independent Monitoring Board (IMB) published its most recent report in August 2008. The report raises the following issues that are relevant to this investigation:

    "The Board has seen positive signs of improvement in the services provided to prisoners, although these have come at a cost to present services.

    "The Board welcomes the renovation of medical suites in the Healthcare Centre while regretting that the cancellation of clinics has led to longer waiting-lists.

    "The Board is concerned that at times because of staff sickness, leave and suspension, the prison has been staffed at a very basic level with the knock on effects on association, visits to the library, attendance of outpatient hospital appointments and other aspects of the regime."

13. Since January 2006 I have presided over 11 other investigations of deaths at Wormwood Scrubs, four of which were from apparently natural causes. In previous investigation reports, I have made recommendations concerning emergency response, CPR training, record keeping, staffing levels and family liaison.

KEY FINDINGS

14. The man was the father of three children, but was separated from his partner. He used his parents' address for contact purposes but was known to live at other addresses. Prior to entering custody he had been working

15. The man appeared in court in August 2008. He was remanded in custody and was due to attend court for sentencing. He arrived at Wormwood Scrubs

16. On arrival at Wormwood Scrubs, the man had a First Health Screen Assessment. At this assessment he told the staff that he had been on prescribed medication for depression and anxiety. His medication was Mirtazapine (an antidepressant) and Quetiapine (an antipsychotic). He said that he was a smoker but did not use drugs. He said that he had recently seen his doctor for a cholesterol count.

17. The next day the man had a General Health Assessment. His weight and blood pressure were taken and both were recorded as normal. He was asked if there was any history of illness in the family and he replied that there was not. He was asked if he wished to give up smoking and he said no. He told the member of staff that, prior to coming into prison, he had been homeless.

18. In August, the man was interviewed by a member of the Mental Health In-reach Team. During the assessment he said that he was worried and anxious, and was missing his children. He also said that he had no intention of hurting himself or others.

19. Five days later, the man was seen by healthcare staff as he said he had experienced pains in his chest. He was advised that he needed to go to the local hospital but he refused to go. His blood pressure was taken, together with an electrocardiograph (ECG) which records heart rhythms. The results of the tests were recorded as normal. His blood pressure was taken again some ten minutes later; it was also within the normal range. He was assessed as fit for light exercise and work as a painter. He was prescribed aspirin and Gaviscon (non-prescription antacid medication for heartburn).

20. The man saw a doctor a week later, as he was passing blood in his stool. A referral was made to the Gastroenterology Department at the local hospital for tests to be undertaken. Samples were also sent for analysis in advance of the outpatient appointment.

21. Three days later the man was seen by the prison doctor. He said that he felt agitated. The doctor increased his prescription for Quetiapine to 50mg just for that day. On assessment the following day, his medication was returned to his normal prescribed level.

22. The test results for blood in the man's stool were returned, and they confirmed the presence of blood. The Gastroenterology appointment had not yet been arranged.

Sunday 21 September

23. The man's cell mate, told my investigator that he and the man had been on morning and afternoon exercise together. By this time the man had been in prison for a month. They were both in their cell, watching television. At approximately 4.45pm, the man told the cell mate that his chest felt tight. The man said that he thought it was heartburn. A short while later the man said that he was getting a pain down his left arm. The cell mate said he would call the nurse but the man did not want him to.

24. The first nurse came round with the evening medication just over two hours later at approximately 7.15pm. In interview for this investigation, the cell mate said that he heard the man ask the nurse to take his blood pressure as his chest felt tight and he had pains down his left arm. According to the cell mate, the nurse told the man that it would be taken in the morning.

25. Both prisoners were lying on their beds when, at around 8.00pm, the cell mate heard him making strange noises and so pressed the cell bell. The first officer responded at 8.05pm and looked through the observation hatch of the cell door. The cell mate told officer that the man was not breathing properly. The officer told my investigator that he saw the man lying on his bed, and could see his chest rise and fall. The officer went to call for a nurse by telephone from the Senior Officer's office. (The officer is not first aid trained.)

26. During the night when a prison is in patrol state there are rules for unlocking prisoners. There should always be a minimum number of staff present, and the cell door should only be opened where there is a threat to life.

27. The second nurse was covering the five main wings. She rang the officer from Healthcare to establish what the problem was. The officer told her that the man was having difficulty in breathing. The nurse checked the man's computer and paper medical records, including his medication chart, before going to B wing. She told my investigator at interview that she did this to ascertain the man's medical history and medication before she went to his cell. She had not been told that assistance was required urgently.

28. At approximately 8.15pm the nurse arrived at the man's cell door. She called to the man and, when she did not get a response, asked the cell mate to shake him. The cell mate told her that there was no response and that the man's arm was cold. The nurse and the officer then went into the cell. The nurse told my investigator that he had a faint pulse, but was unconscious and not breathing. The cell mate assisted the officer and the nurse to lift him to the floor, and the nurse started CPR.

29. The first officer went on to the landing and shouted to an officer to make a Code One radio call. The Code One radio call was made at 8.20pm and a second officer and the SO responded without delay. (At Wormwood Scrubs a Code One call generally signifies that a prisoner is hanging. However, the code is also associated with someone with breathing difficulties.)

30. On arriving at the man’s cell, the second officer and SO took over CPR from the nurse. The SO had recent first aid training. The cell mate was moved to a holding cell on B wing. The nurse left the cell to go to the treatment room on B wing and returned with the emergency bag and defibrillator. She took over the airway management using the air pump (providing breathing to the patient). No one used the defibrillator.

31. The emergency 999 call was recorded by London Ambulance Service (LAS) at 8.26pm and a paramedic was despatched without delay. The detail given in the call by the prison was that it was someone had been found hanging. In addition to the paramedic, an ambulance crew was sent three minutes later. Whilst en route to the prison, the paramedic was informed that a doctor had been sent for at 8.31pm.

32. The paramedic, arrived at Wormwood Scrubs and was at the man’s side a minute later. She saw the prison staff conducting effective chest compressions. However, she told my investigator that she thought the nurse was not being effective with airway management. This was because, in her opinion, the man’s head was not tilted back correctly and there was not a proper seal around the nose and mouth. The paramedic was told by prison staff that CPR had commenced at 8.25pm. She took over the CPR procedure. The paramedic later recorded the time on the LAS Patient Report Form along with the written comment, “On arrival patient lying on cell floor, prison staff doing effective compressions, question effective airway management.”

33. The ambulance crew arrived at the man’s side at 8.45pm. They continued with CPR but made the assessment that he had already died. The paramedic doctor arrived at 8.51pm and pronounced the man’s death at 9.08pm.

Events after the man’s death

34. Whist the paramedics were still in the prison they responded to another emergency call which resulted in the prisoner being taken to hospital. This reduced the number of night duty officers to two as the others were required for escort duty.

35. The SO spoke informally with staff to offer support following the man’s death. The Duty Governor, arrived at the prison and asked the SO if she was alright, offering her the option of going off duty if she thought it necessary. There was no formal Hot Debrief conducted by senior management for the staff involved. There were no written records to document the actions taken by the SO or the Duty Governor.

36. The SO herself told the inmate that the man had died. She told my investigator that she kept checking on him throughout the night to ensure that he was alright.

37. The man’s parents live in Kent, so the prison contacted Kent Constabulary at 11.00pm and asked them to break the news of his death. Sergeant later confirmed that the news was given to the man’s parents. Later that day, the family liaison officer from Wormwood Scrubs, contacted the man’s parents by

telephone. He was told that the man's father had been taken to hospital with chest pains.

38. The Post Mortem report shows that the cause of death was a heart attack.

ISSUES

Clinical care

39. The clinical reviewer highlights the following issues about the man's care:

> "Despite his reported statements of good health prior to his remand, the fact remains that the man was a young man with a moderate to high risk of developing coronary heart disease. Whilst his mental health needs were attended to in a timely and appropriate manner, the review panel identified areas for improvement, specifically surrounding the diagnosis, initial treatment, ongoing care and review of clients with chest pain; and communication with the healthcare/ home office teams.
>
> "Although clinicians use their physical assessment skills to identify deteriorating health and triage patients into the most appropriate care locations, there is evidence that this did not occur in the man's care. Although it is unknown whether the immediate investigation by acute trust specialists would have made a positive difference to his outcome, the failure to holistically assess and seek the guidance of specialists or to apply best practice guidance are serious lapses in care.
>
> "The man was reviewed by locum medical staff once following the first episode of chest pain, and his notes three times. It appears as if each review was considered in isolation and that at no time was his cardiac history revisited.
>
> "The man had a responsibility for his own health and should have proactively sought medical attention. Although improved communication and rapport between the patient and the healthcare staff may have aided the early identification of health concerns and facilitated proactive care planning; it is recognised that this however is not easily attained."

I urge the Healthcare Manager to consider the findings contained in the clinical review.

40. The man continued with the same medication that he was taking before coming into prison. His blood pressure was taken at regular intervals and was within the normal range.

41. In September 2008, the man had told Healthcare that he had chest pains. Despite advice, he refused to go to the local hospital. His blood pressure was taken, along with an electrocardiograph (ECG to record heart rhythms), and the results of these tests were recorded as normal.

42. One of the prison doctors, referred the man to the Gastroenterology Department at the local hospital in September. No appointment had been received by the time the man had died.

43. The clinical review makes the following recommendations which I endorse:

An urgent review of the current policies and guidelines for the quantification and treatment for offenders experiencing angina, chest pain, and cardiac events. It is recommended that this is implemented as a matter of urgency. The adoption of assessment proformas and telemedicine technology may be beneficial.

Following development and implementation, all permanent and locum healthcare staff must be made aware of the chest pain protocol and national best practice and incorporate into daily practice.

Record keeping

44. Some of the records do not contain times of actions taken or have illegible signatures with no printed names. There are specific guidelines for doctors and nurses to complete medical records. It is essential that all contact is recorded accurately and chronologically to ensure there is an accurate and continuous history of a prisoner's needs and treatments.

    I recommend that the Governor and Head of Healthcare ensure that all healthcare staff are reminded of the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

Failure to identify potential serious health risk

45. The man's cell mate, has alleged that the man told the first nurse on the evening medication round that his chest felt tight and that he was getting pains down his left arm, and asked if he could have his blood pressure checked. The man was told that this would be investigated in the morning. My investigator has established from prison records that the nurse was an agency nurse. The nurse only worked at Wormwood Scrubs for two days.

46. It would be expected that a health professional would be alert to the risks presented by the symptoms that the man had described. (They are classic symptoms of a heart attack.) The first nurse could have responded to the man's symptoms herself or alternatively called for urgent assistance. Had the seriousness of his condition been identified at this point, emergency treatment could have been given at a much earlier stage. The police have interviewed the nurse and have provided my investigator with a copy of her statement. In it she states that she has no recollection of having any conversation with the man.

    I recommend that the Primary Care Trust draw my report to the attention of the Nursing and Midwifery Council who should satisfy themselves that the first nurse is competent to practise.

Emergency response

47. The usual number of nursing staff on night duty at Wormwood Scrubs is three. The second nurse was the sole nurse on duty providing healthcare and emergency response to the five wings of the prison. The two other nurses each had a dedicated role in the hospital wing and substance misuse unit. However, on the evening there was no nurse on the hospital wing and, as a result, the nurse was expected to provide cover for that area of the prison as well. The nurse is also an agency nurse.

48. I understand why prisons, particularly in London, are reliant upon agency nurses. However, the use of agency nurses does hinder effective healthcare cover. There is a necessary lack of continuity, along with problems relating to unfamiliarity with the prison layout and its procedures. At interview, the second nurse told my investigator that most nights the healthcare cover is staffed by agency nurses.

    I recommend that the Governor and Head of Healthcare review the level of nursing staff, including the cover for the main prison population during the night duty period.

49. The initial call for assistance made by the first officer provided the nurse on duty with minimal information. The officer had not received first aid or CPR training. The second nurse checked the man's medical records and medication prior to going to his cell on B wing. This was appropriate action given the information provided by the first officer. The nurse arrived at the cell door some ten minutes after the initial call for assistance was made. The nurse only entered into the cell after she received no response when calling to the man, and after asking his cell mate to rouse him. The nurse did not have the emergency bag or defibrillator with her as she had not been told that the situation was an emergency.

50. On entering the cell the second nurse found the man unconscious and not breathing. She said at interview that she felt a faint pulse. The man was moved to the cell floor and the nurse commenced resuscitation. The first officer then asked for the Code One radio call to be made. This was some 15 minutes after the initial request for nurse assistance.

51. The Code One radio call was made over the radio at 8.20pm. The SO and the second officer responded immediately. They took over CPR while the second nurse collected the emergency bag from the treatment room located on B wing.

52. An ambulance was called at 8.26pm, some six minutes after the Code One radio call had been made. Based on the Code One radio call, London Ambulance Service was told that it was an attempted suicide by hanging. Whilst the report was plainly inaccurate, it nevertheless ensured that the prison made an immediate emergency call.

53. On arrival at the cell, the first paramedic who witnessed CPR being conducted was not confident that the airway management technique being used by the nurse was effective. However, the chest compressions performed by the prison staff were being made correctly.

54. The clinical review also draws attention to the chest pain protocol and comments:

> "In the community setting patients with chest pain can access their local emergency department and receive treatment. This standard of care must be made available to those within the prison setting. As a matter of urgency, all offenders who complain of chest pain must be initially assessed and treated by a GP followed by appropriate and timely referral to an acute trust specialist. As a matter of priority, a chest pain protocol must be implemented to ensure that all clinical staff are aware of the treatment options and need for prompt appropriate action."

I recommend that the Governor should review the emergency response with specific attention to clarity of response codes, first on scene protocol and urgent requests for an ambulance.

I recommend that the Governor and Head of Healthcare ensure that all relevant staff have received updated CPR training

Family liaison

55. Prison Service Order 2710, Follow up to deaths in custody, requires that next of kin should normally be contacted face to face as soon as possible after a death has occurred. If the family live too far from the prison, best practice is to ask a dedicated family liaison officer from a prison closer to the family home to break the news. Police should only be asked to break the news if there is a safety risk to staff going to the family home, or for some other pressing reason.

56. In the man's case, Wormwood Scrubs asked Kent Constabulary to break the news to his parents. This was done in the early hours of the morning. Whilst I appreciate the demands on prison staffing during the night, using the police in this circumstance is at odds with the spirit of PSO 2710 and does not, in my view, demonstrate the highest level of care and consideration. Subsequent contact by the prison's family liaison officer has only been via the telephone.

At the consultation stage of the report the Prison Service said that the establishment maintain that there was a need to balance the need to deliver the news personally to the man's family with the need for timeliness. Due to the time of night and the distance in which next of kin live from the establishment the latter seemed to be important. However, in contacting another prison in the vicinity of the family home would still provide the opportunity for a Prison Service official to break the news in accordance with Prison Service policy. Indeed, this has been my experience elsewhere in the Prison Service.

57. The man’s parents have told my investigator that they tried to contact the prison to speak to someone about their concerns for their son’s health. They said there was no point of contact and that there was no one they could talk to. As I have noted earlier, there is in fact a dedicated telephone line for a prisoner’s family and friends to share any concerns they may have about their wellbeing whilst in custody. This is publicised in the Visitors Centre and Visits Hall, amongst other places. The general prison switchboard should advise and refer relevant callers to the dedicated number.

At the consultation stage of the report the Prison Service made the commented that the Hotline is for families to voice any concerns about violence, bullying or self harm issues and is not appropriately managed or resourced for this additional function. Whilst I recognise the Prison Service comment I still maintain that there needs to be a way for families to report genuine concerns about health and well being of prisoners and this, in my view, is appropriate to the safer custody function.

The Governor should ensure that staff deployed as family liaison officers adhere to the guidance provided by PSO 2710 when liaising with bereaved families following a death in custody.

The Governor should satisfy himself that staff operating the general prison switchboard are alerting callers to the existence of the dedicated Safer Custody Hotline. He should also review the publicity material relating to the Hotline to ensure that it is well situated and makes clear that the Hotline can be used by families concerned about general health matters.

Hot debrief

58. There was no formal hot debrief conducted for all the staff involved in responding to the man’s death. The SO provided informal support to the staff on duty at the time. Duty Governor provided informal support to the SO. There is no written record of the support given to staff.

59. Senior management did not hold a formal hot debrief with all the staff involved in the events surrounding the man’s death. PSO 2710 clearly states:

> “There must always be a hot debrief immediately after the incident and provision for this should be made in local contingency plans. A senior member of staff must act as debriefer and a duty care team member must also attend.”

I recommend that the Governor ensures that formal hot debriefs take place in accordance with PSO 2710 and are documented.

RECOMMENDATIONS

For Head of Healthcare

1. An urgent review of the current policies and guidelines for the quantification and treatment for offenders experiencing angina, chest pain, and cardiac events. It is recommended that this is implemented as a matter of urgency. The adoption of assessment proformas and telemedicine technology may be beneficial.

2. Following development and implementation, all permanent and locum healthcare staff must be made aware of the chest pain protocol and national best practice and incorporate into daily practice.

3. I recommend that the Head of Healthcare ensure that all healthcare staff are reminded of the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

4. I recommend that the Primary Care Trust draw my report to the attention of the Nursing and Midwifery Council who should satisfy themselves that the first nurse is competent to practise.

5. I recommend that the Head of Healthcare review the level of nursing, including the cover for the main prison population during the night duty period.

For the Governor

6. I recommend that the Governor should review the emergency response with specific attention to clarity of response codes, first on scene protocol and urgent requests for an ambulance.

7. I recommend that the Governor and Head of Healthcare ensure that all relevant staff has received updated CPR training.

8. The Governor should ensure that staff deployed as family liaison officers adhere to the guidance provided by PSO 2710 when liaising with bereaved families following a death in custody.

9. The Governor should satisfy himself that staff operating the general prison switchboard are alerting callers to the existence of the dedicated Safer Custody Hotline. He should also review the publicity material relating to the Hotline to ensure that it is well situated and makes clear that the Hotline can be used by families concerned about general health matters.

10. I recommend that the Governor ensures that formal hot debriefs take place in accordance with PSO 2710 and are documented.

    At the time of issuing the final report the Prison Service had not provided any responses to the recommendations.