Investigation into the circumstances surrounding the death of a male prisoner at HMP Wolds in February 2009

Report by the Prisons and Probation Ombudsman for England and Wales

October 2009

This is a report into the circumstances surrounding the death of a man in February 2009. He was a prisoner at HMP Wolds and died following a session in the prison gymnasium. The cause of death was a heart attack resulting from coronary artery disease. This underlying problem had not been picked up by medical services during the man's time in custody.

I extend my condolences to his family and friends. I understand prisoners at Wolds undertook a collection to be passed to the family as a gesture of condolence as he was a popular man in the prison.

The investigation was carried out by one of my investigators. In addition, one of my family liaison officers, has been in contact with the man's partner to tell her about my investigation and to ask whether she had any particular questions about his time at the Wolds.

As part of the investigation, a clinical review was undertaken by the East Riding of Yorkshire Primary Care Trust (ERYPCT) and I am most grateful to them for carrying this out. The Director of Wolds should consider its findings and recommendations as well as those that I have made myself.

I should add that I am indebted to the Prison Director and his staff for their support throughout this investigation. I would especially like to mention the prison's liaison officer. He ensured full and unfettered access was given to my investigator, particularly when it came to speaking with prisoners.

Had the man's heart problems been identified, he might have received both appropriate treatment and advice about the exercise regime he was following. I make two recommendations in this report, both of which have been accepted, one in respect of the recognition of coronary heart disease and one on the availability of defibrillators and resuscitation aids. The clinical reviewer makes four recommendations.

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

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SUMMARY

The man who died was serving a life sentence when he was transferred to HMP Wolds in May 2008. He had been at various establishments over the past nine years, including an open prison from which he had absconded. Over the years, he had changed from one who used drugs and committed crime to fund his drug habit, to a man who was well liked and respected by his peers and prison staff alike.

For some years, he had complained about indigestion and had frequently asked to have antacid medication to help sooth the pain and discomfort caused by this condition. In January 2006 and again in March 2006, the man was seen by the prison doctor for his indigestion, but no further clinical assessment was undertaken at this time of the cause.

In February 2007, the man was seen in the healthcare centre at HMP Long Lartin because he was complaining of right sided chest pain, with pain radiating under his right arm and waist. He was supposed to have a follow up appointment with the doctor there, but there is nothing to indicate this happened. He was seen and examined by the prison doctor again on 5 February, complaining of abdominal pain or pain in his liver. Although abdominal pain is not normally associated with cardiac (heart) problems, when viewed in light of the man's earlier visit to healthcare, the possibility of cardiac problems should have been explored. It was not.

After the man's transfer to Wolds, he was referred to an orthopaedic consultant for a long standing knee problem. He went in June 2008 to be seen by a consultant at Hull Royal Infirmary and was subsequently referred for a Magnetic Resonance Imaging (MRI) scan. He had this MRI scan in August which showed that he needed an operation to repair a damaged ligament behind the knee. The man was considering having this operation.

In February 2009, one of the man's friends heard him complaining that he did not want the curry he had ordered for lunch as it would give him indigestion. He offered the man his own lunch. Later that afternoon, the man went to the gymnasium for a session of free weight training (an opportunity for people to use weight lifting equipment the way they wish to use them, rather than in a structured session). He was lifting some heavy weights when he said he needed to rest because he was not feeling well. He thought he might have overdone the weightlifting.

He went back to his cell early from his gym session and had a shower. He was seen by other prisoners and staff, lying on his bed watching rugby. At approximately 4.50pm, the man was locked into his cell by an officer, who spoke with him before closing the door. When the same officer came to unlock him some 20 minutes later, he found him collapsed and unconscious. The officer summoned help from staff on the unit using the radio. Staff arrived and efforts to revive the man were made. When the ambulance arrived they praised the staff for their efforts and took over with their own equipment. They rushed the man to the Hull Royal Infirmary, but sadly they were unable to save his life. The team at Hull Royal Infirmary declared the man dead at 6.15pm

The post mortem revealed that the man had a greatly enlarged heart and that two of the main arteries supplying blood to the heart were hardened by atherosclerosis (which causes a narrowing of the blood vessels). A blood clot was present in one of the main arteries supplying blood to the heart. The pathologist concluded that he had suffered a heart attack as a result of a blood clot blocking one of the main arteries supplying blood to the heart.

The post mortem also revealed that the man had suffered two recent heart attacks, one about 10 - 14 days before he died and one in the hours preceding his death. Neither episode was recorded in his medical notes. It was a feature of the man's personality that he played down the severity of his symptoms and pain. He did not appear to have appreciated the seriousness of his chest pains, preferring perhaps to consider that he was suffering from indigestion rather than having cardiac problems.

THE INVESTIGATION PROCESS

1. This investigation was undertaken by one of my investigators. He first visited HMP Wolds mid February 2009 when he was shown around the prison and given access to the man's prison records. My investigator met members of staff including the Independent Monitoring Board (IMB). (Each prison has an Independent Monitoring Board. IMB members are independent and unpaid. They monitor day-to-day life in the prison and ensure that proper standards of care and decency are maintained.) The IMB had prepared a short report of the events surrounding the man's death, but they had no specific matters to bring to my investigator's attention at the time. Whilst on this visit, my investigator had an informal discussion with a small group of the man's friends who expressed shock and sadness at his passing. My investigator arranged to speak with three of the group more formally on a later visit to the prison.

2. East Riding of Yorkshire Primary Care Trust was asked to undertake a clinical review of the care the man received while he was in custody, although they are not the commissioners of health services in Wolds. My investigator asked the Clinical Reviewer to judge specifically whether the care afforded the man was of an equivalent standard to what might have been expected for a man in his early forties had he not been in custody. In particular, he asked the clinical reviewer to consider the emergency medical response procedures and whether the identification of potential risk factors for a man of his age had been reasonably dealt with by health services at the prison.

3. One of my Family Liaison Officers wrote to the man's family in March to explain the purpose of the investigation and invite them to raise any concerns they wished to be considered and addressed as part of the investigation. The main matter raised by the man's family was that they had heard he had a history of heart disease recorded on his medical records. This was at odds with information they knew about him. They thought he was a fit man who would have told them if he had any health concerns of this nature and would have reported this to his doctor. They wished me to investigate this matter as part of my investigation.

4. My investigator contacted HM Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem and the toxicology reports. Upon completion, a copy of my report will be sent to the Coroner to assist his enquiries into the circumstances surrounding the man's death.

5. Shortly after the man's death an article written by a prisoner at Wolds, appeared in a prison newspaper, *Inside Time*, entitled 'Profit before care'. The author of that article asserted a number of things, including that the man had been complaining for weeks about having chest pains. He also gave details of there being no healthcare staff after 3.30pm on the day the man died. The, Director of Wolds, responded to the author's letter in the following month's edition of *Inside Time*, rejecting much of what the article's author had to say. The man's family were aware of this article and they checked to ensure that I had seen it. In addition, my investigator interviewed the author. .

6. It is evident from the reaction of prisoners who came forward to speak with my investigator that the man was well liked by both prisoners and staff. He had numerous reports from staff over recent years that praised him for having turned a corner in his life. He had held responsible positions in a number of the prisons (such as visits orderly).

HMP WOLDS

7. HMP Wolds opened in early 1992 as a remand prison, but in 1993 it was changed to become a category B local prison. It has subsequently been changed to be a category C training prison with a particular function of serving the needs of second stage lifers. (Prisoners on life sentences have to progress through their sentence complying with plans and objectives set for them by offender managers. Second stage lifer prisons are part of these plans and will often be providers of offence-related courses or vocational training designed to equip prisoners with skills to allow them to be released back into the community.) Wolds is operated by the private firm G4S and accommodates 395 adult male prisoners aged over 21 years on medium to long term sentences. The prison offers several courses designed to address offending behaviour and a variety of daytime and evening education classes, as well as more mainstream skills training in workshops.

8. The healthcare services are provided by Primecare under a contract with G4S. Primecare provide nursing cover throughout the core day. This is 7.30am until 8.30pm on Mondays to Thursdays. On Fridays the nursing staff are on duty from 7.30am until 6.00pm and at weekends they are on duty from 8.30am until 4.30pm. There are no in-patient services at Wolds.

9. Wolds received an unannounced follow up inspection by HM Chief Inspector of Prisons, in September 2007. In her report, the HM Chief Inspector of Prisons wrote that Wolds deserved considerable praise for the work they had done to build on the strengths identified at the previous inspection and for acting on the areas requiring improvement. Healthcare services were described as ‘reasonable’.

10. The prison’s Independent Monitoring Board in its annual report for 2007–2008 mentions that the prison was listed as an exceptionally high performing prison (level 4). (This means that the prison consistently meets or exceeds targets set for them and that there are no operating problems.) The IMB report says nothing in respect of services delivered by Primecare, save for a description of those services. However, the Prison Services quarterly performance ratings for 2008 and into 2009 show that Wolds has dropped in its performance ratings to level 2, which means that the prison has areas that require development. This would have been the case at the time of the man’s death, but it is not clear from these performance measures in what areas Wolds was now failing in its performance.

11. There had been no earlier deaths at HMP Wolds since I was given responsibility for investigating all deaths in prison custody in 2004. Since the death of the man there has been one more. I am not yet at the stage where I can determine if there will be similar recommendations to those I have made in this report.

KEY FINDINGS

12. The man was remanded into custody at HMP Manchester in July 1998 for a series of robberies committed over a three month period that year following his release from HMP Risley. He was convicted in May 1999 at Manchester Crown Court and sentenced to life imprisonment in July. His 'tariff' was set at five years (the tariff is the minimum amount of time a life sentence prisoner must serve in custody before they can be considered for release on licence).

13. After a difficult start in prison, the man seems to have settled down and in November 2004 the Parole Board recommended that he be transferred to an open prison. From a health perspective, his only problem was recurrent trouble with his left knee. Throughout 2003 and 2004, these problems had persisted and he was referred to an orthopaedic consultant in Leeds. (It is unclear why he was referred to Leeds as he was at HMP Gartree in Leicestershire during this time.)

14. In February 2005, he was transferred to HMP Sudbury from Gartree. However, in June that year he absconded from Sudbury and committed further offences whilst at liberty. He was arrested in mid June and returned to Sudbury. He was sentenced to life imprisonment again at Derby Crown Court with a tariff of four years nine months in September 2005 for the offences committed whilst he was unlawfully at large.

15. At this time the man was at HMP Nottingham. He complained of heartburn in January 2006 for which he was given some peptic liquid to settle his stomach. On 26 January, the man complained of dizziness and blurred vision, nausea and a mild headache brought on by climbing the stairs. When he was seen by the prison doctor, he was advised that he might be suffering these symptoms because he was trying to give up smoking. He declined a cholesterol test. His blood pressure was checked on 10 February – it was 135/65 (it had been 135/85 on 26 January). Both results are within normal limits.

16. The man was seen on 3 March and again on 7 March because he had injured his toe. He had been given ibruprofen (an anti-inflammatory pain reliever) for this injury, but on 7 March he also complained of heartburn. When he was seen following a back injury in the gym on 20 March, the medical record says that ibruprofen upset his stomach (this is a common side effect with drugs like ibruprofen).

17. On 29 September 2006, the man was transferred to HMP Long Lartin. Whilst there, the prison doctor prescribed ibruprofen for his knee pains, but added Gaviscon to counteract the stomach upset this would cause. On 1 February 2007, he attended the healthcare centre at Long Lartin complaining of right sided chest pain that could be felt under his right arm and down to his waist. His pulse was recorded as 152/99 (too high) and his pulse was 54 (a bit slow, but not at a level to worry about). He was not sweating nor was he feeling sick. He was supposed to have been seen by the prison doctor, but it does

not appear that he was. However, he was seen again three days later when he complained of abdominal pain (described as possibly coming from his liver in the notes), and this time he was seen by a prison doctor. It is not clear from the notes what actions were taken as the entry is illegible, but it does not appear that he was seen again whilst he was at Long Lartin.

18. On 24 October 2007, the man was moved to HMP Blakenhurst (now part of HMP Hewell). His problems with his knee were noted, as was his problem of getting an upset stomach from the use of ibruprofen. He requested a low fat diet on 20 December to help him lose weight.

19. He was transferred to HMP Wolds on 1 May 2008 and it was noted in his medical records that he was waiting for an appointment with an orthopaedic consultant. On 30 June, the man saw the consultant at Hull Royal Infirmary who confirmed that he had an anterior cruciate ligament rupture of his left knee (damage to the ligaments behind the knee) and would need an MRI scan (a scanning device that uses magnetic and radio waves to identify deep tissue problems). He had his MRI scan on 7 August and was seen again on 20 October by the consultant. He was told he would need an operation to correct his knee problem.

20. In early February 2009, the man was in the cell of his friend. The friend remembers that the man complained of pains in his chest and pointed to his upper arms and shoulders when he described where the pain was. The friend said that he and the man had a laugh and a joke about this being heart related, but the man said he would see a doctor about it.

21. In interview, the friend recalled that the next day he had heard the man complaining in the dinner queue that he did not want the curry that he had ordered because it gave him indigestion. The friend said that the man could have his dinner because he was getting ready to go on a visit and he did not want to eat.

22. Later that day the man went to the gymnasium, as he often did, to do some weight training. The Physical Training Instructor (PTI) told my investigator that the man was an enthusiastic weightlifter, a serious weight trainer who was doing exercises to improve the strength of his chest muscles. The PTI said that the man was one of about 30 prisoners who were using the gymnasium that day. The man completed his usual warm up exercises and moved onto the weights training. Shortly before 4.00pm, he went to the PTI and told him that he was not feeling well. He told the PTI that he thought he had overdone the weightlifting and would like to return to his cell to lie down and watch the rugby on television.

23. The man arrived back on the unit at about 4.15pm and was seen by the Prison Custody Officer (PCO). The PCO spoke with the man who confirmed that he had returned from the gym early because of feeling unwell. Another friend of the man was on the unit at the time. He saw that the man went to have a shower. In interview, the friend said that he thought that the man appeared a bit ‘down’ when he talked to him in the shower, but he had not

wanted to pry as to the cause of the man's quietness. The friend said that he had a bit of a laugh and a joke with the man a little while later, when he was watching the rugby back in his cell. The friend and the rest of the prisoners were then locked in their rooms for a roll check prior to their evening meal being served. (At least three times a day, usually first thing in the morning, at lunch time and late afternoon, the number of prisoners has to be checked by physically counting them to ensure they are all within the prison.) The PCO remembered locking the man's door because he recalled that he was laid on his bed watching the rugby and he had asked him the score. Although he did not recall exactly what he replied, in interview the PCO said that the man did reply to his question. He then locked the man's door at approximately 4.50pm.

24. The PCO returned to the man's cell at approximately 5.10pm to unlock him for his evening meal. When he entered the cell he saw the man was laid on his back with his head on the hot water pipes. The PCO turned the cell light on and discovered that the man was unconscious, with his eyes open, and looked to be a bluish colour. The PCO summoned immediate medical assistance using the radio and shouted across the landing for one of his colleagues, another PCO. The two PCO's then moved the man onto the floor and whilst one PCO went to fetch a ventaid resuscitation mask, the other PCO tried to raise some response from the man, but to no avail.

25. At approximately 5.14pm the duty manager for the prison, arrived at the man's cell and asked that an ambulance be called for. He then commenced cardiopulmonary resuscitation (CPR). Other staff arrived and arrangements were made to meet the paramedic staff to escort them to the unit where the man was. The first responder paramedic was on the prison site by 5.16pm and an ambulance was on site by 5.19pm.

26. Paramedic staff were escorted to the man's cell, where the deputy manager for the prison was continuing with CPR attempts. There was reported to be a small delay in the ambulance crew gaining access to the man's cell due to other prisoners needing to be returned to their cells first. However, the ambulance crews took over from the deputy manager and attached their monitors to the man. They continued their efforts to revive him, leaving the prison at approximately 5.50pm.

27. The paramedics took the man to Hull Royal Infirmary, but they were unable to save his life. He was pronounced dead at 6.10pm. It was not clear from prison records who should be treated as next of kin initially. The prison chaplain contacted a person who was due to be visiting the man the following day. It transpired this was his partner and unfortunately this resulted in her being given the news of his death that evening by telephone. He apologised for breaking the news in this manner, and his partner is said to have understood.

28. The post mortem report gives the cause of death as a heart attack. It also says that it is most likely the man suffered a heart attack 10 to 14 days before his death and a further heart attack in the hours just prior to his death.

ISSUES

Clinical Issues

29. The man was in early middle age and looked generally fit and healthy. He was slightly overweight and was a smoker, but he was taking active steps to reverse these health concerns. He had made a few attempts over the years to stop smoking and had tried to reduce his weight. He used the gymnasium as often as he was allowed, and had moved a long way from his early years as a drug user when he first came into prison in 1998. Furthermore, he had made good progress in tackling the roots of his offending and in his general attitude to authority through participating in offending behaviour programmes.

30. When the man arrived at Wolds in May 2008, he underwent a health assessment, including a health screening for his use of the gymnasium. This consisted of some questions about his general health, including ‘do you have a history of heart problems?’ and ‘do you have any physical disability?’ He declared ‘No’ to each of these questions. He was additionally seen by a doctor regarding his knee problems, and the doctor wrote a referral letter to Hull Royal Infirmary’s orthopaedic department on 2 May. The referral ultimately resulted in the man being seen in October 2008 by an orthopaedic consultant who recommended corrective surgery for his left knee.

31. The man had been complaining of heartburn and indigestion for a number of years, and had been taking antacid medication throughout that time. A friend of the man who used the gym a lot with him and who lived on the same unit, told my investigator that the man would complain almost daily about heartburn. On the day he died, the friend remembers that the man had complained he did not want the curry he had ordered for dinner because it gave him terrible indigestion. The friend offered the man his own dinner.

32. The friend also remembers that, the day before he died, he and the man were talking together in his cell when the man told him of pains in his shoulders and upper arms. The friend advised him to seek medical help as both he and the man thought this might be heart related. The man said he would seek help, but laughed about it later.

33. The clinical reviewer is critical of health services provided to the man regarding his indigestion. As far back as 2003, he had complained of having an upset stomach and was given an antacid medication to counteract this. His discomfort was often associated with the use of non-steroidal anti-inflammatory drugs such as ibruprofen. Indeed, in January 2007 he was prescribed ibruprofen and Gaviscon (the Gaviscon to counteract the side effect of upset stomach that ibruprofen can cause). At no time was any further investigation ever made of his gastric discomfort. The clinical reviewer points out the man should have been assessed on no fewer than three occasions for whether his symptoms were cardiac or gastric in nature.

34. On 26 January 2006, the man complained of dizziness and blurred vision when climbing the stairs (when he was at HMP Nottingham). His blood

pressure result was not a cause for concern, and his other symptoms did not indicate a cardiac problem (no shortness of breath, chest pain or palpitations).

35. However, the clinical reviewer highlights two further occasions where there should have been more thorough assessments of the man's presenting problems. On 1 February 2007, when the man was at Long Lartin, he went to healthcare and complained of right sided chest pain. His blood pressure was high at 152/99 and, although he was not sweating nor complaining of feeling sick, the clinical reviewer suggests that more effort should have been made at this time to consider whether he had any cardiac problems.

36. The man was seen again at Long Lartin on 5 February 2007, complaining of abdominal pain in the region of the liver. He was examined by the prison doctor who felt the man's stomach to determine whether he had any inflammation but who could not find any obvious cause. The man was due to have an ultrasound investigation of his abdomen on 2 August, but he did not attend this appointment (it is not clear from the records why). The clinical reviewer again points out that no consideration that these pains might have been cardiac in nature appears to have been made.

37. The clinical reviewer summarises her concerns as follows:

> "It is the view of the clinical reviewer that the most significant factor in relation to the outcome would appear to be that at no time does it appear that the man's risk factors in relation to coronary heart disease had been taken into account and that a plan of care to manage the risk factors had been developed. No evidence could be found in his records that he had at any time been offered advice regarding diet, exercise and weight loss."

38. This points to a failure by health services within both Long Lartin and Wolds to consider chronic disease management for the man. The risk factors for coronary heart disease were present in that he was a smoker, with a slight weight problem, who had abused drugs significantly in the past. Combined with a history of chest pain and no definitive diagnosis for the cause of his gastric pain, it is surprising that no consideration was given to the possibility that he might have a chronic heart condition. Had this been recognised, he might have received advice about the exercise regime he was following.

Healthcare staff at Wolds and Long Lartin should be trained in the recognition and management of coronary heart disease. This should include recognition of the risk factors, clinical management, supporting health promotion programmes, and monitoring systems.

Emergency response issues

39. The author of the Inside Time article alerted my investigator to the possibility that healthcare staff had left the prison early on the day that the man died. He said that the evening medication was issued between 3.00pm and 3.30pm and in a rushed manner. My investigator enquired about the finishing times of

nursing staff at the weekend and was told they would normally finish their duty at 4.30pm. The man was found collapsed at about 5.10pm, and indeed he was seen to be alive at approximately 4.50pm by a PCO Both these events are some time after nursing staff would have normally gone off duty. I therefore have not investigated his concerns any further. However, the Director will wish to ensure that effective management checks are in place at the weekend to ensure that nursing staff are on duty when they should be.

40. When the PCO first found the man unconscious in his cell, he called for assistance from his colleague. They moved the man initially away from the hot water pipe, and then went and got the first aid kit out of the office. One of the PCO's used the ventaid in the first aid kit to help with mouth to mouth resuscitation on the man. When the PCO put the ventaid into the man's mouth he checked for airway obstruction. It was at this point that the prison duty manager arrived and first started CPR. Both PCO's are first aid trained (as is the duty manager), but they were delayed in starting CPR by the lack of protective mouth to mouth equipment. Although this was only for a short time (it has been described as being only a few seconds, although the timings in paras 24-25 above suggest it may have been longer), I think the Director of Wolds should consider making resusciaides available to all staff as part of their personal protective equipment. When someone is found collapsed, even a few seconds delay can make all the difference to the success of the resuscitation effort.

41. Of equal concern to me is the lack of use of any defibrillation machine. The Duty Manager and PCO were both asked by my investigator if they knew where a defibrillator was in the prison. Neither knew for certain, and both said that, even if they had known, they were not trained in its use (and this would have been true of all staff on duty at this time). It is impossible to say if this would have made any difference to the outcome for the man's care, but in other circumstances it might literally be the difference between life and death.

The Director of Wolds should ensure there are sufficient defibrillation machines available within the prison and that sufficient staff are trained in their use. He should also consider making resusciaides available to all staff as part of their personal protective equipment.

42. Once it became evident that the man had died, the support offered to staff was excellent. Every member of staff involved was offered support from staff welfare services. The care of prisoners was also reasonably well managed, particularly by the chaplaincy (it was quite quickly known by prisoners on his unit that the man had died). Communication of his death to the wider prison was perhaps a little slow which resulted in rumours and half truths circulating about the circumstances.

43. The post mortem suggests that the man may well have suffered a heart attack some 10 – 14 days prior to his actual death. Evidence from the clinical record does not show him attending healthcare at this time nor any other evidence of his complaining of chest pains. Similarly, the post mortem report says that he may well have suffered a heart attack in the hours before he died, in addition

to the heart attack that killed him. It is conceivable that the pain and discomfort that caused the man to leave the gymnasium, might have been that heart attack. Similarly, when the man was telling his friend about his pains the previous evening, this might have been when he was having his earlier heart attack. It would appear, in any event, that he made less of his condition than he perhaps should have. It may be he believed that his symptoms were simply indigestion, and he therefore did not realise the severity of the situation. Given that medical professionals had not identified any cardiac problems, the man could hardly have been expected to have made such a diagnosis himself.

RECOMMENDATIONS

An Action Plan with a target date of 31 December 2009 has been put in place for the following recommendations:

Healthcare staff at Wolds and Long Lartin should be trained in the recognition and management of coronary heart disease. This should include recognition of the risk factors, clinical management, supporting health promotion programmes, and monitoring systems.

The Wolds have accepted the above recommendation. Long Lartin said:

> At Long Lartin health care staff are trained in the recognition and management of Coronary Heart Disease. To include recognition of risk factors, clinical management, supporting health promotion programmes and monitoring systems. In light of this I will ensure that this training is updated annually.
>
> We have an established clinical service which supports CHD management which encompasses treatment for hypertension. This is led by a nurse who has considerable experience in Coronary Heart Disease and holds a qualification in Cardiac Management.

The Director of Wolds should ensure there are sufficient defibrillation machines available within the prison and that sufficient staff are trained in their use. He should also consider making resusciaides available to all staff as part of their personal protective equipment.

This recommendation is accepted. The Wolds said:

> Additional defibrillators are being purchased and will be located in easily accessible places.
>
> For all staff to carry resusciades is impracticable (over a period of time they can become soiled and they can be easily damaged) so, all living unit first aid boxes contain a resusciade.