

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Raymond York a prisoner at HMP Hewell on 10 May 2015

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## 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*



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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 Raymond York was found hanged in his cell at HMP Hewell on the evening of 9 May and died in hospital in the early hours of 10 May. He was 53 years old. I offer my condolences to Mr York's family and friends.

When Mr York arrived at the prison, less than two weeks before his death, staff did not identify him as at risk of suicide, despite clear information that he had recently tried to kill himself and other risk factors. This was a serious omission, and the failure to identify and respond to known risk factors for suicide and self-harm is a matter I have raised with Hewell in a number of previous investigation reports

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**November 2015**

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# Summary

## Events

1. On 27 April 2015, Mr Raymond York was remanded to HMP Hewell, charged with assault. This was his first time in prison. Court staff completed a suicide and self-harm concern form indicating that Mr York had recently attempted suicide. Mr York's escort record, which went with him to the prison, also recorded that Mr York had previously attempted suicide, most recently in February 2015. Reception staff and a nurse assessed Mr York, but did not identify him as at risk of suicide and self-harm.
2. The next day, healthcare staff received Mr York's community GP records, which recorded that he had taken eight overdoses in recent years. Six months previously, he had been referred to community mental health services. No one assessed the records properly or reconsidered his risk of suicide and self-harm or referred him for a mental health assessment.
3. On 9 May, another prisoner moved in with Mr York after violently damaging his own cell. This prisoner had recently threatened to stab a cellmate, but no one had reviewed his risk for sharing cells. Mr York's new cellmate said he fallen asleep on the evening of 9 May and, when he woke up around half an hour later, shortly before 9.00pm, he found that Mr York had hanged himself by tying a towel around his neck, attached to the bed frame. His cellmate removed the ligature and alerted staff, who responded quickly to the emergency. Prison staff tried to resuscitate Mr York but no one used a defibrillator until paramedics arrived about ten minutes later and were able to re-establish a pulse. The paramedics took Mr York to hospital, but he died in the early hours of 10 May.

## Findings

4. The investigation found that staff missed several opportunities to identify Mr York's risk of suicide and self-harm. We consider he should have been managed under Prison Service suicide and self-harm prevention procedures, and referred to the mental health team, when he first arrived at Hewell. Although there is nothing to suggest that Mr York's cellmate was involved in Mr York's death, we are concerned that no one had reviewed his risk assessment for sharing a cell, after he had threatened to stab his previous cellmate. There was a significant delay before anyone used a defibrillator during the resuscitation attempt. We make five recommendations.

## Recommendations

- The Governor should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that reception and first night staff:
  - Have a clear understanding of their responsibilities and the need to share all relevant information about risk.

- Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide and self-harm, including information from suicide and self-harm warning forms, PERs and other sources.
- Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.
  
- The Head of Healthcare should ensure that healthcare staff review prisoners' community GP records promptly and begin ACCT procedures when records indicate a prisoner is at risk of suicide and self-harm.
- The Head of Healthcare should ensure that all healthcare staff are aware of the circumstances in which a mental health referral is appropriate and make an assessment when indicated.
- The Governor should ensure that cell sharing risk assessments are reviewed whenever there is information that a prisoner is at increased risk of violence towards a cellmate.
- The Head of Healthcare should ensure that adequate and appropriate equipment is kept with the emergency response bag, that it is checked regularly and that staff use a defibrillator quickly when someone's heart has stopped.

## The Investigation Process

5. The investigator issued notices to staff and prisoners at HMP Hewell informing them of the investigation and asking anyone with relevant information to contact him. Five prisoners asked to speak to him.
6. The investigator visited Hewell on 19 May. He obtained copies of relevant extracts from Mr York's prison and medical records. He spoke to the prisoners and viewed closed circuit television (CCTV) footage of the events of 9 May.
7. NHS England commissioned a clinical reviewer to review Mr York's clinical care at the prison.
8. The investigator interviewed eight members of staff and two prisoners at Hewell on 24-25 June. The clinical reviewer joined the investigator at for interviews with healthcare staff on 25 June. Mr York's cellmate would not agree to be interviewed.
9. We informed HM Coroner for Worcestershire of the investigation and have sent the coroner a copy of this report.
10. One of the Ombudsman's family liaison officers contacted Mr York's estranged wife, who he had named as his next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr York's estranged wife had no immediate issues for the investigation.
11. Mr York's estranged wife received a copy of the initial report. She pointed out some factual inaccuracies. This report has been amended accordingly. Mr York's estranged wife also raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

## Background Information

### HMP Hewell

12. HMP Hewell is an amalgamation of two prisons, the former HMP Blakenhurst, and HMP Hewell Grange. The Hewell Grange site continues to operate as an open prison and the Blakenhurst site is a secure, local prison. Mr York was at the Blakenhurst site which comprises six houseblocks, holding around 1100 men. Worcestershire Health and Care NHS Trust provide health services.

### HM Inspectorate of Prisons

13. The most recent inspection of HMP Hewell was in July 2014. Inspectors reported significant weaknesses in reception and first night procedures, including a failure to conduct first night assessments for all new arrivals. They reported that the number of prisoners managed under ACCT arrangements was high and increasing and there were more incidents of self-harm than at comparable prisons. Inspectors also found that a previous recommendation, that all cell sharing risk assessments should be regularly reviewed, had not been achieved. Inspectors found that the personal officer scheme did not work effectively and many prisoners said they did not have a personal officer. Inspectors found mental health services were adequate. Progress on implementing PPO recommendations from investigation into deaths at the prison had been slow.

### Independent Monitoring Board

14. 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 2013-2014 annual report, the IMB noted that, in recent years, there had been a significant increase in incidents of self-harm and bullying. They reported that staff were more vigilant, with increased numbers of prisoners supported for risk of suicide and self-harm.

### Previous deaths at HMP Hewell

15. Mr York was the 11<sup>th</sup> prisoner to die at Hewell since January 2014, the fifth apparently self-inflicted death. Our investigations into the deaths of men in June 2014 and August 2014 found that reception staff had missed clear opportunities to identify their risk of suicide and self-harm.

### Assessment, Care in Custody and Teamwork

16. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the

actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## Key Events

17. On Saturday 25 April, Mr Raymond York was arrested and charged with assault. A police doctor assessed him, and noted that Mr York was depressed and had previously attempted suicide. On Monday 27 April, he appeared at court and was remanded to Hewell. His Person Escort Record (PER, a form that accompanies prisoners on all journeys to communicate information including about risk factors) stated that Mr York suffered from depression and had attempted suicide by overdose in 2013 and in February 2015. A member of court staff had also completed a self-harm/suicide concern form and recorded that Mr York had seen a crisis team in October 2014 and said he had attempted suicide. The form noted that he should be “assessed and monitored” when he arrived in prison.
18. At 5.45pm on 27 April, Mr York arrived at Hewell. This was his first time in prison. The duty supervising officer (SO) interviewed Mr York when he arrived, but told the investigator he could not remember him. He did not assess him as at risk of suicide and self-harm and did not begin ACCT procedures.
19. Nurse A assessed Mr York and noted the medication that he had with him, including citalopram (an antidepressant). Mr York said he was asthmatic and drank 96 units of alcohol per week. The nurse saw the PER and the self-harm/suicide concern form and wrote on each, “States that he has no thoughts of self-harm/suicide at this time”. The nurse could also not remember Mr York or how she had reached her conclusion that he was not at risk. She told us that she assesses risk by considering whether the prisoner has a history of mental illness or self-harm, questioning how they feel at the time and judging their demeanour. She did not refer to any of the specific risk factors for suicide and self-harm for prisoners set out in Prison Service Instruction (PSI) 64/2011, covering safer custody. The nurse referred Mr York to a GP because of his physical health and reported alcohol use but did not refer him for a mental health assessment.
20. An officer completed a cell sharing risk assessment (CSRA), which is used to determine whether someone would present a risk of violence to another prisoner in a shared cell. The officer noted that this was Mr York’s first time in prison and he had no thoughts of self-harm. The officer assessed Mr York as suitable to share a cell.
21. On 28 April, a psychosocial worker completed an initial substance misuse assessment. He noted that Mr York showed no signs of withdrawal symptoms from alcohol and that Mr York had taken an overdose six months previously, after an argument with his girlfriend. He did not consider Mr York was at risk of suicide and self-harm so did not begin ACCT procedures.
22. Dr A then assessed Mr York. Mr York said he had taken an overdose six months earlier, after an argument, but now felt fine. The doctor did not regard him as at risk of suicide. He prescribed vitamins to help with Mr York’s alcohol withdrawal.

23. SO B then completed a basic custody screening, a tool designed to identify issues affecting short-term prisoners. The template includes questions about risk, including the risk of suicide and self-harm, but SO B did not use them. He said that he had been told not to complete this section during training, but now does.
24. On 28 April, the prison received Mr York's community GP records. These indicated that he had been prescribed various medications including citalopram, for depression, and tramadol (a strong painkiller), for pancreatitis. His GP recorded that Mr York had taken eight overdoses between 2007 and October 2014 and had cut his throat during this last incident. (His GP record did not refer to the most recent reported incident of overdose in February 2015.) After the overdose in October 2014, Mr York's GP had referred him to a consultant psychiatrist. The psychiatrist had concluded that Mr York did not need specialist follow-up, but Mr York agreed to see a primary care psychiatric nurse at the GP practice. There is no record to indicate that Mr York attended any sessions with the nurse. It is not clear whether any member of healthcare staff reviewed the record when they arrived. No one reassessed his risk or a need for a mental health referral based on the information in the records.
25. On 29 April, Nurse B completed a secondary health screen. Mr York said he had taken an overdose of tramadol six months earlier, when he had split up with his wife (although we understand that Mr York and his wife had been apart for some years). Mr York said he was okay now and did not intend to harm himself. The nurse could not remember Mr York, or whether she had seen his GP records, which had arrived the day before and outlined some of his previous overdoses and psychiatric history. She did not see the information from the escort record or the self-harm/suicide concern form, which referred to his suicide attempt in February 2015. She did not assess him as at risk of suicide and self-harm.
26. Mr York was prescribed various medications at Hewell, including citalopram and tramadol. He collected these each day at the Houseblock 4 treatment hatch, and a nurse supervised him taking them.
27. On 30 April, Nurse C reviewed Mr York and noted that he had still not reported any withdrawal symptoms. The nurse decided he did not need any further oversight from substance misuse services.
28. Mr York shared a cell on Houseblock 4 with prisoner A. Prisoner A said that Mr York was quiet and they got on well. He said that Mr York had some medical problems, which meant that he sometimes lost control of his bowels. (There is no record that Mr York had reported this to healthcare staff.) Prisoner A did not think that Mr York had any problems in the prison, such as being bullied or getting into debt. On 7 May, Prisoner A moved out of the cell to share with one of his friends.

29. At lunchtime on 9 May, another prisoner on Houseblock 4, prisoner B, badly damaged his cell for the second time that week and made it uninhabitable. SO C said that she had spoken to prisoner B about this and he had appeared like a scared child and was annoyed with himself for taking drugs, which had led to the violent outbursts. (Other prisoners told us that prisoner B smoked 'mamba', a synthetic cannabis or new psychoactive substance that can be considerably stronger than cannabis.) The SO said she spoke to prisoner B for some time about coping mechanisms and the help he could get from drug services in the prison. She said that he was tearful but calm. He moved from the damaged cell to share Mr York's cell.
30. On the evening of 9 May, another prisoner, prisoner C, saw Mr York in the medication queue and thought he seemed low. The prisoner asked Mr York about this, but Mr York said he did not feel comfortable talking in the queue. The prisoner said he would speak to him later, but he did not have the opportunity. He told us that he thought he had told a member of staff that Mr York seemed down, but could not remember who this was.
31. At around 6.00pm, Officer A locked Mr York and prisoner B in their cell for the night. He said that Mr York had seemed his normal self at the time.
32. Prisoner B did not want to speak to the investigator about the evening's events but, in a statement for the police, said that Mr York had appeared quiet and depressed that evening. Prisoner B said that he went to sleep in the evening and was woken around half an hour later by a choking sound. (The estimated times prisoner B gave the police were incorrect so we have not repeated them here.) He said when he woke Mr York was hanging by a towel around his neck, tied to the bed frame. Prisoner B said he cut the towel with a plastic knife and pressed the cell emergency bell to get help from staff.
33. The night patrol officer (an operational support grade), A, responded to the cell bell. CCTV footage shows he arrived at the cell at 8.58pm. Prisoner B told OSG A what had happened and OSG A then radioed a code blue medical emergency (indicating a life-threatening situation). The prison's control room called an emergency ambulance straight away.
34. Nurse D was working on Houseblock 4 at the time, and OSG A went to get her and then opened the cell. OSG A took Prisoner B out while Nurse D examined Mr York. She found that he was not breathing and had no pulse, and began cardiopulmonary resuscitation. Nurse E, the emergency response nurse, arrived at 9.05pm, with an emergency bag. An officer took over chest compressions while the nurses attempted to administer oxygen; however, the machine did not work. Nurse D brought a larger cylinder, which they were able to operate but were unable to use because of vomit obstructing Mr York's airway. The suction unit in the emergency bag was not powerful to remove the amount of vomit present. There were no gloves in the emergency bag and the nurses did not use a defibrillator to try to establish a heart rhythm as they were attempting to clear Mr York's airway.

35. Paramedics arrived at 9.16pm and took over the resuscitation attempt. They were able to clear Mr York's airway. They used a defibrillator and re-established a pulse. At around 10.00pm, paramedics took him to the Alexandra Hospital, Redditch. Mr York did not recover and at 3.00am on 10 May, hospital doctors pronounced his death.

### **Contact with Mr York's family**

36. Mr York had not had any contact with his family for several years and had not listed a next of kin. West Mercia Police traced his estranged wife and informed her of his death on the afternoon of 10 May. The deputy governor telephoned Mr York's estranged wife and, with a family liaison officer, visited Mr York's estranged wife, his mother and his sister on 12 May, to offer condolences and support. Mr York's funeral was held on 26 August. In line with Prison Service instructions, the prison contributed to the costs of the funeral.

### **Support for prisoners and staff**

37. After Mr York's death, an operational manager, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer her support and that of the staff care team.
38. Prisoner B spent time with a Listener (a prisoner trained by the Samaritans to support other prisoners in distress) before moving into a cell with another prisoner. The prison posted notices informing other prisoners of Mr York's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr York's death.

### **Post-mortem report**

39. A post-mortem examination established the cause of death as hanging. A consultant forensic scientist specialising in knots and ligatures, examined the ligature and found no evidence of any third party involvement in Mr York's death. Toxicology tests identified no illegal or unprescribed drugs.
40. The post-mortem examination also established that Mr York had fractured his nose. A specialist in the process of fractures examined this further and found that Mr York had two recent fractures; the first was two to four weeks before his death, and the second was 36 to 48 hours old at the time he died. We do not know the circumstances in which Mr York fractured his nose; at the time of the first fracture, it appears that Mr York was not in prison. There is no record that he told anyone about the second break and nothing to explain how it happened.

# Findings

## Management of risk of suicide and self-harm

41. The Prison Service Instruction (PSI) covering safer custody, PSI 64/2011, lists a number of risk factors and potential triggers for suicide and self-harm. These include early days in custody, previous self-harm, being charged with violent offences, and first time in custody. Staff should interview new prisoners in reception to assess their risk of suicide and self-harm. All staff should be alert to the increased risk of suicide or self-harm posed by prisoners with these risk factors and should address any concerns, including opening an ACCT if necessary.
42. Mr York's escort record (PER) recorded that he had attempted suicide in 2013 and in February 2015. Court staff also completed a self-harm/suicide concern form to alert prison staff to his recent suicide attempt. It was Mr York's first time in prison, he had been charged with a violent offence, he took antidepressant medication and he had been referred for mental health support.
43. PSI 07/2015, about early days in custody, states the following mandatory action for prison reception staff:

*“The PER and any other available documentation including Suicide and Self-Harm Warning Forms ... must be examined, and the prisoner interviewed in Reception, to assess the risk of self-harm.”*
44. Hewell's local policy, revised in March 2015, goes further and states that reception staff must open an ACCT for any prisoner who arrives with a self-harm warning.
45. Neither the reception SO nor Nurse A remembered Mr York. The SO signed the PER to confirm that he had received Mr York into custody, but it is not clear whether he read and noted the information about his risk, as he should have done. Nurse A signed the PER and the suicide and self-harm concern form, and wrote on each of them that Mr York had said he had no thoughts of suicide or self-harm at the time. Although Nurse A could not recall seeing Mr York, she speculated that she did not open an ACCT because Mr York had said that his past actions were “nothing” and his demeanour suggested that he was well.
46. In a PPO thematic report, published in April 2014, about risk factors in self-inflicted deaths, we found that too often assessments of risk place insufficient weight on known risk factors and too much on staff perceptions of the prisoner's behaviour and demeanour. Mr York had several risk factors for suicide and self-harm – it was his first time in prison, he was charged with a violent offence, had been diagnosed with depression and there was clear information that he had previously attempted suicide, including recently. We consider that reception staff should have begun ACCT procedures and their own local policy required this.

47. Our recent investigations into the deaths of two men at Hewell in June 2014 and August 2014 also found that reception staff did not begin ACCT procedures for men who arrived with suicide and self-harm warning or concern forms, which indicated a significant risk of suicide and self-harm. In response to our recommendations, Hewell undertook to deliver refresher safer custody training to all operational and healthcare staff who work in reception, and said that all SOs working in reception would receive additional training to include sharing and recording all known risk factors for newly arrived prisoners. Some, reception staff have completed this training but the SO and Nurse A said that they could not recall receiving any additional advice or training.
48. Hewell also revised its local safer custody policy to place more emphasis on identifying and sharing information about risk factors for suicide and self-harm. However, we saw no evidence of any systematic or coordinated assessment of Mr York's risk in reception and staff did not appear to have been aware of their responsibilities. Although staff said they could not recall Mr York, there was little recorded to indicate which risk factors they had taken into account when assessing his risk. We repeat our previous recommendation:

**The Governor should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that reception and first night staff:**

- **Have a clear understanding of their responsibilities and the need to share all relevant information about risk.**
  - **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide and self-harm, including information from suicide and self-harm warning forms, PERs and other sources.**
  - **Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.**
49. There were other missed opportunities for staff to identify Mr York's risk of suicide and self-harm. On 28 April, the day after he arrived, Mr York spoke to a nurse and a doctor about taking an overdose in October 2014, but they did not review his risk. Later that day, SO B did not complete the basic custody screening section about risk. He told us that he now recognises the need to complete this section.
50. Mr York's community GP records arrived at the prison on 28 April. The records showed that he had taken eight overdoses in the community in recent years. Nurse B completed a secondary health screen the day after the records arrived, but did not refer to them and could not remember if she had seen them. Her notes indicate that she spoke to Mr York only about one overdose, rather than a pattern of behaviour. There is no evidence that anyone else reviewed Mr York's GP records. This was a missed opportunity

to assess Mr York's history of attempted suicide and should have prompted staff to begin ACCT procedures. We make the following recommendation:

**The Head of Healthcare should ensure that healthcare staff review prisoners' community GP records promptly and begin ACCT procedures when records indicate a prisoner is at risk of suicide and self-harm.**

### Mental health

51. Mr York's escort record and suicide/self-harm concern form recorded recent suicide attempts. He brought his medication, including an antidepressant, to prison with him. Although Nurse A did not assess him as at risk of suicide and self-harm, we are concerned, in the light of his recent suicide attempt, that she did not refer Mr York for a mental health assessment. As noted, no one appears to have reviewed Mr York's community GP records when they arrived, which would have reinforced the need for a referral to the mental health team. We make the following recommendation:

**The Head of Healthcare should ensure that all healthcare staff are aware of the circumstances in which a mental health referral is appropriate and make an assessment when indicated.**

### Cell sharing risk assessment

52. Several prisoners told us that they were concerned that prisoner B was not an appropriate person to share cells with Mr York, who was older and quieter. They said it was well known that prisoner B used 'mamba' (a synthetic form of cannabis known as a new psychoactive substance) and was a bully who would do anything he could to get tobacco and drugs. They were suspicious that Mr York had hanged himself on the day that prisoner B began to share the cell with him and believed this must have influenced his decision or that prisoner B had played some part. The police investigated this and were satisfied that there were no suspicious circumstances. A specialist who examined the towel Mr York had used to hang himself did not find any reasons to suspect third party involvement.
53. Prisoner B would not talk to the investigator and we have therefore not been able to discuss his account of events. Although there is no evidence that he was involved in the events that led to Mr York's death, we are concerned that the prison had not reassessed his risk for cell sharing. On 22 April, prisoner B had told his offender manager that he heard voices in his head telling him to stab his cellmate and Officer A spoke to prisoner B about this. Officer A told us that prisoner B said he was just trying to manipulate the system to get a single cell and he reported this back to the manager of Houseblock 4. No one reviewed prisoner B's cell sharing risk assessment (CSRA), which is used to determine whether someone would present a risk of violence to another prisoner in a shared cell. Prisoner B continued to be allowed to share a cell.
54. PSI 9/2011, the instruction that covers cell sharing risk assessment procedures, states that prisons must ensure that there is an up-to-date cell sharing risk assessment for all prisoners. It requires that standard risk

assessments should be reviewed where new or additional information becomes known which indicates increased risk, and reviews must be carried out or approved by a multi-disciplinary team. Prisoner B gave specific information about his thoughts, which suggested that he presented an increased risk to his cellmate. Although he gave an officer an explanation for this, we consider this should have triggered a review of his cell sharing risk assessment, including healthcare staff. We make the following recommendation:

**The Governor should ensure that cell sharing risk assessments are reviewed whenever there is information that a prisoner is at increased risk of violence towards a cellmate.**

### Emergency response

55. When prisoner B said he had found Mr York hanged, OSG A, raised the alarm using the appropriate emergency code, opened the cell quickly and the prison called an ambulance immediately. Nurse D started chest compressions and officers took over. We consider that this was quick and appropriate immediate emergency response.
56. The nurses then had difficulty removing vomit from Mr York's airway, as the suction unit in the emergency bag was not powerful enough. There were no gloves for them to use and they could not manage to operate the original oxygen cylinder. Their efforts to remove the vomit meant that they did not use a defibrillator, and one was not used until paramedics arrived ten minutes later. The clinical reviewer commented that early defibrillation is one of the key elements for survival in advanced life support and even with the problems the staff encountered, the delay in using a defibrillator was too long. We make the following recommendation:

**The Head of Healthcare should ensure that adequate and appropriate equipment is kept with the emergency response bag, that it is checked regularly and that staff use a defibrillator quickly when someone's heart has stopped.**