Prisons & Probation Ombudsman
Independent Investigations

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Policy into Practice: Emergency Response

I am pleased to introduce this latest Policy into Practice publication. The *Policy into Practice* series focuses on how the Prisons and Probation Ombudsman sees HMPPS policy frameworks being applied. This publication combines policy and case studies to highlight the learning from our investigations and some important policy requirements.

The PPO has investigated numerous deaths where the prison's emergency response procedures have required improvement. We shared this learning with the Directorate of Security while they consulted on their draft policies. As these policies have since been published, we have taken this opportunity to flag the recurring issues we see in our cases and relevant parts of the policies. We urge prisons and staff to remain aware of the following issues.

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The Managing Conveyance on Unauthorised and Illicit Items Policy Framework ("Managing Conveyance Policy") and the Management of Internal Security Procedures Policy Framework ("Internal Security Procedures Policy") were first piloted at two sites and, after consultation, were published nationally on 31 July 2024. These policies form part of the broader National Security Framework ("NSF") and contain information on emergency response procedures.

Roll check: Staff are to assure themselves that prisoners are alive and well.

The Internal Security Procedures Policy replaces a number of PSIs, including 13/2011 on Management and Security of Communication/Control rooms and Internal Prisoner Movement. As such, it outlines the procedures to follow during roll check. Annex A to the policy contains the roll check template form and instructions on roll check procedures.

As a result of the findings from our investigations into fatal incidents, we suggested that the new policy needed to address the importance of using roll checks to see if a prisoner is safe and well.

We were pleased to see that the Annex A now sets out that: **"Staff are to assure themselves that prisoners are alive and well during roll check."**

The annex also makes clear that: **"When checking the roll, staff must assure themselves that prisoners are in their cells by obtaining a clear view of their face, if necessary, by waking them."**

Roll checks are crucial to maintaining security within prison and identifying any potential escapes, but they also provide a valuable opportunity to check on prisoners' safety. The case study below highlights the significance of staff completing roll checks correctly.

Case study: An officer arrived at the Care and Separation Unit at around 7:10am and began her roll check. The officer said she believed the prisoner was alive and standing in the middle of the cell and saw nothing to cause any concern. At around 8:15am, the prisoner was found hanging from the ceiling light with his feet off the ground. His body was cold and there were clear signs of rigor mortis. Paramedics reached the cell at around 8:32am and declared the prisoner dead one minute later. We concluded that almost certainly the prisoner was already hanging during the roll check and the officer failed to notice this.

Procedures at night: The preservation of life takes precedence and the Night Orderly Officer should hold weekly briefings with staff.

The Internal Security Procedures Policy includes the procedures for staff entering a cell at night. Under normal circumstances, authority to unlock a cell at night must be given by the Night Orderly Officer ("NOO") and cells should not be opened unless a minimum of two/three members of staff are present. However, staff have a duty of care to prisoners, to themselves and to other staff, and the preservation of life takes precedence over these directions.

"Where there is, or appears to be, immediate danger to life, then cells may be unlocked [following a dynamic risk assessment and informing the communications/control room] without the authority of the NOO and an individual member of staff may enter the cell on their own." The policy provides further guidance on factors staff should consider.

The PPO has made repeat recommendations that Governors should ensure night staff understand this.

A prison's Local Security Strategy (LSS) should have further detail on the procedures staff should follow if faced with a potentially life-threatening situation at night. The policy also sets out that: **"All night staff must be briefed at the start of the week by the NOO and made aware of the actions to take in an incident."** Serious self-harm and death are listed as incidents which must be covered. Prisons should check that NOOs are delivering these briefings. The following case study illustrates the delays that can be caused when night staff do not understand the policy.

Case study: At around 5:30am, an officer began his count of prisoners. He could see the side of a prisoner's face, which he said looked a "funny colour". He radioed for other prison staff to attend the segregation unit, stating that he "thought a prisoner had ligatured". He did not open the cell as he said he had been told that he had to call the night manager and wait for them to arrive before entering a cell. Nearly five minutes passed from when the officer arrived at the prisoner's cell until it was opened. In these circumstances, where an officer thinks a prisoner might be hanging, we would expect prison staff to go into a cell as soon as possible, after making a dynamic risk assessment.

Calling an emergency code: Is the prisoner conscious and breathing?

Staff use emergency medical codes (normally code red or blue) to alert healthcare and others in the prison that there is a medical emergency. Following this alert and in line with policy, the control room will immediately call for an ambulance.

However, in order for the ambulance dispatch operators to send the ambulance immediately and with the appropriate priority, control room staff must be able to answer key triage questions, normally whether the prisoner is conscious and breathing. We find that often, control room staff do not have this information and might try to put the call through to the wing office but, as staff are attending the emergency, they are unable to take the call.

This leads to delays and/or the ambulance dispatch operator sending a lower priority ambulance.

During consultation, the PPO suggested that the Internal Security Procedures and the Managing Conveyance Policy include reminders that where staff use the emergency medical codes, they should also inform the control room whether the prisoner is conscious and breathing. The case study below illustrates the delays caused when control room staff do not have relevant information.

Case study: Two prisoners looked into a prisoner's cell and saw him sitting on a chair with bedding tied around his neck and to the window bars. The prisoners alerted an officer who called a medical emergency code. A supervising officer in the wing office radioed this and control room staff immediately called for an ambulance.

The prison control room failed to pass on basic information to the ambulance dispatch operator. It took two minutes for the ambulance operator to establish which prison the staff were calling from, and that the prisoner was not breathing. It took four minutes for the call to be transferred to the wing where the ambulance call handler was given full details of the circumstances.

HMPPS have issued medical emergency response cards which make it clear that staff responding to an emergency should inform the control room of whether the individual is breathing and conscious.

Escorting emergency vehicles: Ensure staff are familiar with the prison's Local Security Strategy (LSS).

We have investigated numerous deaths where there have been delays in escorting ambulance staff to the incident. The Managing Conveyance Policy makes it clear that there need to be instructions within the LSS about the admission of emergency vehicles.

These instructions should include:

- procedures for clearing the gate area,
- the process of identifying staff to escort the vehicle and any additional gate staff to open gates on route, and
- how to escort any emergency vehicles during prisoner movements. This final point was added to the Managing Conveyance Police at the PPO's request after investigating the case below.

Case study: Following an emergency call where CPR was being delivered by prison and healthcare staff, paramedics arrived at the prison at 2:02pm, followed by two more ambulances. The paramedics did not reach the incident until 18 minutes later. This was because officers were not immediately made available to escort the ambulance, and it was time for prisoner movements, so staff were uncertain of the procedures to allow the ambulance through. On reaching the patient, paramedics continued resuscitation attempts and took the prisoner to the local hospital where doctors declared he had died.

Prisons should make it clear whose responsibility it is to manage an incident and staff should be aware of these responsibilities. In this case, the orderly officer did not know that, under the LSS, it was their responsibility to make officers available to escort the ambulance, believing that the gate staff would do this.

Movements is a busy time and staff will reasonably be cautious about opening internal gates to allow an ambulance to pass. Prisons must have clear local guidance on the procedures to follow under those circumstances and ensure that staff are familiar with it.

Authorisation for devices: Gate staff must be clear on what emergency staff can carry with them when attending an emergency.

We have investigated cases where ambulance staff attending emergencies in prisons have faced delays and difficulties entering prisons with the technology they need to administer clinical care.

The Managing Conveyance Policy and the quick guide on Emergency Vehicles (annexed to the policy) makes it clear that ambulance staff may bring their patient device (which is a laptop/pad containing medical applications) into a prison for the purpose of delivering clinical care. Ambulance staff are also permitted to enter the prison with mobile phones (both work and personal).

These phones can be used by staff to access the same medical apps as the patient device and to contact the receiving hospital to ensure quick and effective treatment. To minimise delays in ambulance staff reaching the patient, any phones and devices not being used for clinical use should be securely stored in the ambulance (either in the ambulance's locker or the glove box). Where possible, gate staff should quickly account for phones both entering and leaving the prison.

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