Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Mesut Olgun, a prisoner at HMP Hewell, on 14 June 2018

## A report by the Prisons and Probation Ombudsman

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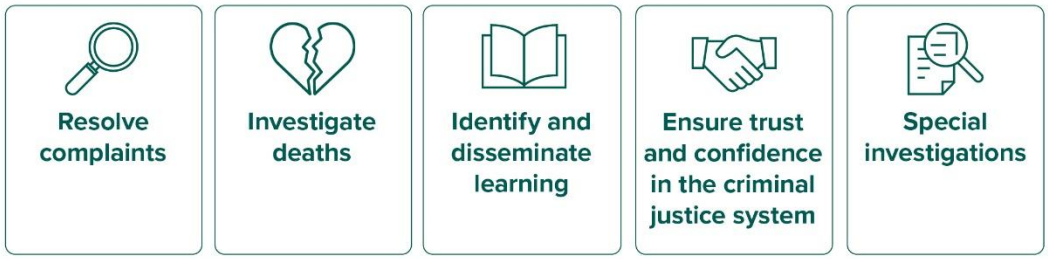
## OUR VISION

**To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.**

## WHAT WE DO




## WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Mesut Olgun died after he was found hanged in his cell on 14 June 2018 at HMP Hewell. He was 30 years old. I offer my condolences to Mr Olgun's family and friends.

Mr Olgun was recognised as being at high risk of suicide and self-harm when he arrived at Hewell on 7 June. He met the criteria for constant supervision but staff put him on four checks an hour. I do not know if this would have been sufficient to keep Mr Olgun safe because the night patrol officer did not make the required checks. He was convicted of misconduct in a public office in November 2023. This criminal investigation led to the delay in issuing this report.

I recommend that if a prisoner meets the criteria for constant supervision but staff decide against it, there is a documented multi-disciplinary discussion to justify this. I also consider that using interpreting services would have helped staff to properly assess Mr Olgun's risk.

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

**Adrian Usher**
**Prisons and Probation Ombudsman** **May 2026**

# Contents

# Summary

## Events

1. At 3.30am on 6 June 2018, police were called to an incident where Mr Mesut Olgun was breaking shop windows. Mr Olgun was armed with a meat cleaver and cut his throat when police arrived. He injured a police dog and resisted arrest. The police took him to hospital for treatment to his injuries and put him under constant supervision in their custody.

2. On 7 June, Mr Olgun appeared at court and was remanded to prison. Court custody staff checked him six times an hour and completed a suicide and self-harm warning form. They also contacted HMP Hewell to warn them that Mr Olgun was on his way to them and was at high risk of suicide and self-harm.

3. Staff started Prison Service suicide and self-harm monitoring procedures (known as ACCT) in reception and a nurse assessed Mr Olgun. Staff decided that he would be subject to four checks every hour. Mr Olgun was assessed as unsuitable to share a cell due to his risk to potential cellmates.

4. At about 6.47am the following morning, prisoners from the adjacent open prison noticed Mr Olgun hanging in his cell when they were picking up litter from the exercise yard. Their civilian supervisor alerted prison staff. Staff cut Mr Olgun down and started CPR assisted by prison nurses. Paramedics took Mr Olgun to hospital but he died six days later.

5. Subsequent investigations by the prison and police discovered that the night patrol officer had not made the required checks on Mr Olgun and falsified the ACCT record. He has since been found guilty of misconduct in a public.

## Findings

6. Mr Olgun met the criteria for constant supervision when he arrived at the prison. He had recently seriously self-harmed and said he had thoughts of suicide. The circumstances of his alleged offences also gave cause for concern in terms of his mental health. It is not clear who initially decided that four observations per hour would be sufficient for Mr Olgun. A missing part of the ACCT document compounded this issue. There is no evidence that a conversation took place between staff to decide on the appropriate level of observations for Mr Olgun. In addition, the night patrol officer did not complete the necessary observations overnight and falsified records to say that he had done so.

7. Police records indicated Mr Olgun needed an interpreter. Staff at Hewell did not use an interpreter which would have helped them to more accurately assess Mr Olgun's risk to himself and others.

## Recommendations

- The Governor should ensure that when prisoners meet the criteria for constant supervision, a documented multi-disciplinary conversation takes place to determine

the appropriate level of ACCT observations if they are not subject to constant supervision.

# The Investigation Process

8. HMPPS notified us of Mr Olgun's death on 14 June 2018.

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

10. The investigator obtained copies of relevant extracts from Mr Olgun's prison and medical records and CCTV from 8 June 2018. She also obtained further information from West Midlands Ambulance Service and West Mercia police. She interviewed six members of staff between June and August 2018.

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

12. Our investigation was suspended at the request of West Mercia police in September 2018, pending an investigation into the actions of the night patrol officer on the night of 7/8 June. The night patrol officer was subsequently convicted of misconduct in a public office. At the conclusion of his criminal trial in November 2023, we unsuspended our investigation.

13. We informed HM Coroner for Worcestershire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

14. The Ombudsman's family liaison officer contacted one of Mr Olgun's uncles to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Olgun's uncle asked for detail about Mr Olgun's time in Hewell and how often he had been monitored. The investigator subsequently met two of Mr Olgun's uncles and their solicitor when our investigation was suspended to inform them of our findings so far.

# Background Information

## HMP Hewell

15. HMP Hewell holds up to 900 adult male prisoners on remand or serving short sentences. Physical healthcare is provided by Practice Plus Group (formerly Care UK). Midlands Partnership Foundation Trust provide mental health services and substance misuse services are provided by Inclusion.

## HM Inspectorate of Prisons

16. The most recent inspection of HMP Hewell was in December 2022. Inspectors reported that the prison had made excellent progress since the previous inspection in 2019 and was cleaner, more decent and safer. Disappointingly, failings in the care of prisoners in their early days in custody remained a priority concern. Inspectors found that not enough was being done to support prisoners most at risk of suicide and self-harm. There was no strategy or action plan, limited data analysis and investigation of serious self-harm incidents, and poor oversight of implementation of PPO recommendations.

17. HMIP conducted an independent review of progress at Hewell in November 2023. Inspectors found that early days in custody arrangements still needed improving and too little was being done to reduce self-harm. The recorded rate of self-harm had not reduced and was on an upward trend. The quality of ACCT case management remained too variable.

## Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 30 September 2023, the IMB reported that overcrowding at the prison had got worse and prisoners were often locked up for 22 hours a day. Despite these challenges, the IMB found that staff tried to deliver a safe, fair and humane regime. However, self-harm incidents had risen again and the key work scheme had not functioned as intended due to short staffing.

## Previous deaths at HMP Hewell

19. There was one self-inflicted death at HMP Hewell in the three years before Mr Olgun died. In that we identified some issues with ACCT management. Up to the end of 2023, there had been nine self-inflicted deaths since Mr Olgun's, with the most recent in July 2023. Of these, four have identified issues in the assessment and management of the prisoner's risk to themselves. Two are still currently under investigation but early findings involve issues with management of the risk of suicide and self-harm.

## Assessment, Care in Custody and Teamwork

20. 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 multidisciplinary review meetings involving the prisoner.

21. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan 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

22. Details about Mr Mesut Olgun's background are scarce. He was a Turkish national whose last visa to stay in the UK expired in 2009. Mr Olgun previously served a sentence in HMP Bristol in 2012 and was considered for removal from the UK under immigration powers. However, after release from prison, he failed to keep in touch with the immigration authorities and was listed as 'out of contact'.

## Police and court custody, 6 – 7 June 2018

23. At 3.30am on 6 June 2018, a member of the public witnessed Mr Olgun breaking shop windows and called the police. Police told the investigator that Mr Olgun was under the influence of alcohol and drugs, might have been having a psychotic episode and had a meat cleaver in his possession. The first officer on scene was a dog handler. Mr Olgun started cutting his own throat, so the handler released his dog to try to stop him. Mr Olgun then attacked the dog and the handler and other officers had to intervene.

24. The police took Mr Olgun to hospital where he received treatment for his injuries. Cuts to his arms and legs were steri-stripped, a cut to his head was stapled and the self-inflicted wounds to his neck were stapled and stitched. He was given a tetanus injection and antibiotics for a dog bite. Police records do not indicate that Mr Olgun had a mental health assessment.

25. After treatment in hospital, Mr Olgun was taken to a police station. The police assessed him as at high risk of harm to himself and others and placed him under constant supervision. At 11.00am, a police medical officer examined him and decided he needed further treatment in hospital due to a high heart rate and possible atrial fibrillation (irregular heartbeat). He was discharged back to police custody after receiving further treatment and medication for his injuries. He did not receive a mental health assessment.

26. During the afternoon of 6 June, a police medical officer determined that Mr Olgun was fit for interview but that he needed a Turkish interpreter. Police waited four hours for one to arrive. Mr Olgun said he had mental health issues and described visual and auditory hallucinations. He said he was not receiving treatment for his mental health. Mr Olgun told police that he had tried to harm himself before, most recently by cutting his throat just before he was arrested.

27. On 7 June, Mr Olgun was charged with criminal damage, causing unnecessary suffering to an animal, possessing an offensive weapon in a public place, affray and assault occasioning actual bodily harm.

28. At 8.14am, Mr Olgun was taken to court. His person escort record (PER) showed that he had cut his throat on 6 June, had mental health issues and was a risk to himself. The front page and risk indicator page were marked "*HIGH RISK*" in several places and the front page included reference to the interpreting services which had been used. Mr Olgun arrived at court at 9.25am and court custody staff observed him six times an hour.

29. Court custody staff completed a suicide and self-harm warning form and attached it to Mr Olgun's PER. They ticked boxes to indicate that Mr Olgun had made statements of intent to self-harm or kill himself, had harmed himself within the previous month and noted Mr Olgun "seems very depressed." Staff recorded that Mr Olgun had cut his own throat the previous day and was at high risk of hurting himself. They noted that Mr Olgun had hardly spoken during the day. Mr Olgun was remanded to custody and taken to HMP Hewell.

## HMP Hewell, 7 – 8 June 2018

30. Mr Olgun arrived at Hewell at about 5.00pm. A supervising officer (SO) was in charge of reception. He said he received a telephone call from GEO Amey (who were transporting Mr Olgun to prison) alerting him that Mr Olgun was on the way to the prison and was a high risk of suicide and self-harm. The SO was told that Mr Olgun's offence was high profile and that he had cut his throat the day before. The SO spoke to Mr Olgun at the reception desk and said he did not appear distressed or unwell.

31. At 5.15pm, an officer completed Mr Olgun's cell sharing risk assessment (CSRA) and started Prison Service suicide and self-harm monitoring (known as ACCT). She noted on his CSRA that Mr Olgun's case was high profile and had been in the news the previous day. She also noted Mr Olgun had mental health issues and had said he wanted to kill himself. She concluded that Mr Olgun was a high risk to others if he shared a cell. This meant that Mr Olgun would not share a cell on his first night as was the usual practice at Hewell. The Duty Governor approved the officer's decision.

32. The SO said that he anticipated that Mr Olgun would be put under constant supervision in the prison's inpatient unit so, while Mr Olgun had his initial health assessment with a nurse, he rang a custodial manager (CM) so she could start arranging extra night staff.

33. The nurse said he looked briefly at Mr Olgun's injuries without completely removing the dressings because he did not have the necessary medical supplies to redo the dressings. (These would have been changed the next day.) From his brief examination, the nurse noted that the self-inflicted cut to Mr Olgun's throat was superficial and not close to an artery. This was in contradiction to police records which noted that the wound had been stapled and stitched.

34. The nurse said Mr Olgun could speak and understand English well. He told him that he had broken a shop window and then waited for the police because he felt under threat from an individual in the community. The nurse said he explored this issue with Mr Olgun but could find no evidence of paranoid, psychotic or delusional beliefs. Mr Olgun was clear that the person he was under threat from was not in prison and said he felt safe and relieved now he was in Hewell.

35. The nurse said he explored Mr Olgun's risk of suicide and self-harm and asked him why he had cut his throat. Mr Olgun said he was angry with the police but was not clear about his arrest and why he had cut himself. The nurse said he felt like he could not get to what was at the root of Mr Olgun's actions. Mr Olgun told him that he had no current thoughts of suicide or self-harm.

36. The nurse said an ACCT had already been opened by reception officers and Mr Olgun had been put on four observations an hour. He considered constant supervision but said in his opinion there was no clinical reason Mr Olgun needed that level. He appeared quite calm, and the nurse was satisfied that observations every 15 minutes would pick up any changes in his mental state that might require increased observations. He said he discussed the level of observations with the SO. The nurse sent referrals to the GP and the mental health team for Mr Olgun to have follow-up appointments. He also gave him some co-amoxiclav (an antibiotic) for the dog bites and referred him to nurses to have his dressings checked the next day.

37. The SO said Mr Olgun was with the nurse for about 45 minutes, which is a long time for a reception interview. He said the nurse came to see him in his office afterwards and told him that he thought Mr Olgun did not need constant supervision and four checks an hour was sufficient. The SO said he deferred to the nurse's opinion because he knew he was an experienced mental health nurse and had spent a long time talking to Mr Olgun.

38. An officer completed Mr Olgun's first night in prison interview in the first-night centre on Houseblock Three. She said Mr Olgun appeared distant and upset and gave one-word answers. The officer asked him if he felt suicidal or like harming himself and Mr Olgun answered yes to both. The officer explained about the Listeners (prisoners trained by The Samaritans to offer confidential peer support), the Samaritans phone (a mobile telephone with a direct line to The Samaritans), the mental health team and the Chaplaincy. She said Mr Olgun looked blank and upset as if he was not taking in the information she was giving him. The officer spent about 15 minutes with him, trying to get him to talk more openly, but he remained the same.

39. At the end of the interview the officer briefed the wing SO and the other staff on duty. She said she and the other staff on duty checked Mr Olgun more often than four times an hour because they were so concerned about him. The officer asked Mr Olgun how he was every time she checked him, and he put his thumbs up. When an operational support grade (OSG), the night patrol officer, came on duty, she briefed him before stopping work around 8.45pm.

40. A nurse said he remembered giving Mr Olgun his medication at about 9.00pm. He said Mr Olgun had a lot of bandages but was mentally well and did not appear distressed.

41. The OSG was suspended from duty pending an internal investigation when interviews took place and we have not spoken to him. The OSG completed the ACCT record to indicate that he had checked Mr Olgun four times an hour between 9.00pm and 10.00pm, once between 10.00pm and 11.00pm and then four times an hour until 6.10am on 8 June. The investigator was provided with CCTV from 5.00am to 7.22am on 8 June. During this period, the OSG completed the ACCT record to show he checked Mr Olgun at 5.10am, 5.25am, 5.40am, 5.55am and 6.10am. CCTV showed the OSG only checked Mr Olgun once at 5.36am by the CCTV clock (which we calculated was about 12 minutes behind the correct time). We understand from the police that the OSG made very few checks on Mr Olgun during the night.

## Emergency response

42. At about 6.45am on 8 June, a civilian employed by the Prison Service to supervise waste management was supervising a small group of prisoners from a nearby open prison cleaning rubbish from the Houseblock Three exercise yard. He said that that a prisoner told him that he thought he could see a prisoner hanging in one of the ground floor cells. He said that he immediately used his keys to enter the houseblock as he knew the night orderly officer (officer in charge of the prison at night) had an office there. He alerted a CM and the OSG that a prisoner might be hanging in one of the cells.

43. The clock on the CCTV was wrong so we have used the times from the incident logs and ambulance records. The OSG got to Mr Olgun's cell first, looked through the observation panel, banged on the door and used his radio. Within a minute, the CM joined him. He too looked through the observation panel and used his radio before opening Mr Olgun's cell door. At 6.47am, staff noted in the incident log that staff had called for a "response" and nurse to Houseblock Three. No one radioed a code blue emergency.

44. Mr Olgun was hanging from the locker on his wall by a ligature made from his sheet. The CM supported Mr Olgun's weight while the OSG cut the ligature. They laid Mr Olgun on the floor and the CM started cardio-pulmonary resuscitation (CPR).

45. Four minutes later, at 6.51am, a nurse arrived with emergency equipment and began assembling it outside the cell. He radioed a code blue. (An emergency code used when a prisoner is not responding or having difficulty breathing). Staff in the control room immediately requested an ambulance which was dispatched with the highest priority within a minute.

46. The nurse attached a defibrillator to Mr Olgun. It advised no shock but to continue CPR. Another nurse got to the cell and gave Mr Olgun oxygen via an ambu-bag.

47. At 7.01am, paramedics arrived and took over resuscitation. They gave Mr Olgun adrenaline and his heart restarted but he was unable to breathe unaided. At 7.42am, they took Mr Olgun to hospital. Mr Olgun remained unresponsive in intensive care until he died on 14 June.

## Contact with Mr Olgun's family

48. Mr Olgun did not list any next of kin when he first arrived at Hewell. The police and prison contacted Mr Olgun's next of kin on 8 June to inform them he was in hospital and an uncle visited him there the same day. On 9 June, the prison appointed a family liaison officer who maintained contact with the family. On 14 June, the prison Imam completed the Islamic rites at the request of the family, who were present when Mr Olgun died. The prison made a financial contribution to Mr Olgun's funeral in line with national guidance.

## Support for prisoners and staff

49. After Mr Olgun's death, the CM debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

50. The prison posted notices informing other prisoners of Mr Olgun's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Olgun's death.

## Post-mortem report

51. The pathologist gave the cause of death as hypoxic brain injury (lack of oxygen to the brain) due to hanging. Toxicology tests showed Mr Olgun had no alcohol or drugs in his system.

## Investigations after Mr Olgun's death

52. On 21 June, the Deputy Governor asked the Head of Security to investigate the checks made by the OSG on Mr Olgun during the night of 7/8 June. In light of the Head of Security's investigation, the Governor at the time held a disciplinary investigation. The investigator requested a copy of the Head of Security's investigation, but the prison declined to provide it. She was provided with a copy of the terms of reference and a copy of the outcome which was sufficient in the circumstances. The then Governor found that the OSG had not made the required checks and had falsified the ACCT record. He re-graded the OSG to a non-operational administrator role and issued him with a final written warning to remain in force for two years.

53. West Mercia police also investigated the OSG's conduct that night. In November 2023, he was found guilty of misconduct in a public office. At the time of writing he was awaiting sentence.

## Coroner's Inquest

54. A Coroner's inquest concluded on 8 December 2025. The medical cause of death was given as hypoxic brain injury (lack of oxygen to the brain) as a result of hanging. The jury concluded that the failure of the OSG to carry out all required observations and a delay in calling a code blue emergency caused or contributed to Mr Olgun's death.

# Findings

## Assessment and management of risk

55. Mr Olgun had a number of risk factors that indicated he was at high risk of suicide on 6 and 7 June. He had suicidal thoughts, had expressed a desire to kill himself, gave a history of poor mental health and appeared very depressed. Most seriously, on 6 June, he made cuts to his throat that required stapling and stitching at hospital. The police treated this as a suicide attempt, recognised he was high risk and put him under constant supervision. Court custody officers also deemed him at high risk of suicide and self-harm. They monitored him six times every hour and, unusually, telephoned Hewell prior to his arrival in addition to completing a suicide and self-harm warning form.

56. Reception staff at Hewell began ACCT monitoring as soon as Mr Olgun arrived and set the level of observation at four checks an hour. The SO and initial health assessment nurse gave contradictory accounts of how this level was arrived at. The SO said he assumed Mr Olgun would be under constant supervision and had begun the process of calling in extra staff to facilitate this. He said that when the nurse decided four observations an hour were sufficient, he deferred to him as an experienced mental health nurse. The nurse said that the level of four observations an hour had already been set by reception staff before he assessed Mr Olgun. He said he began the assessment thinking constant supervision was likely but concluded that four observations an hour was enough once he had spoken to Mr Olgun. The ACCT document showed the SO recorded four observations an hour on the cover, but the entry has no time. In addition, the immediate action plan, which should have been completed by a prison manager within an hour of the ACCT being opened, was not provided to the investigator. This would have included the level of observations for Mr Olgun. The prison have not been able to determine whether this is because the action plan was lost, or one was not completed at the time.

57. However the decision was arrived at, both the nurse and SO were aware of the level of observation and neither tried to persuade the other that constant supervision was necessary.

58. Guidance on constant supervision is contained in Prison Service Instruction (PSI) 64/2011, *Safer Custody*. This has been revised and expanded since Mr Olgun died. At the time, the PSI gave three reasons for the use of constant supervision:

    - Serious attempts and/or compelling preparations for suicide e.g. making a ligature, hoarding medication and/or writing a suicide note.
    - Credible expression of a wish to die.
    - A recent and credible attempt to take own life e.g. both in prison and recently prior to imprisonment.

    The PSI made clear that these examples were for guidance only and that each case should be considered individually and not in isolation by any one person.

59. According to this guidance, Mr Olgun fitted the criteria for constant supervision as he had recently seriously self-harmed and said he had current thoughts of suicide. The police had treated him cutting his throat as a suicide attempt. The nurse asked him about this but said that he was unsure what Mr Olgun's intentions were. Staff judgement is fundamental to the ACCT system. The system relies on staff using their experience and skills to make a considered, objective evaluation of all risk factors when assessing the risk of suicide and self-harm. We do not consider that it would be helpful or appropriate for us to criticise the nurse's judgement call with the benefit of hindsight. The nurse spent 45 minutes with Mr Olgun and came to a considered conclusion that four observations an hour were sufficient. What is less clear is whether there was any effective discussion as both the SO and the nurse credited each other with setting the frequency of observations.

60. We do not know whether four checks an hour would have been enough to keep Mr Olgun safe because the OSG did not check him at the required frequency. However, he last checked Mr Olgun just under an hour before he was found hanged, so we consider that Mr Olgun should have been checked three or four times between then and being found hanging. Given that nearly six years has passed since Mr Olgun's death, it is difficult to make meaningful recommendations. However, following a death at the prison in 2022 for which the investigation remains ongoing, we have preliminary concerns that staff in reception did not adequately assess the risk information available to them (including that the prisoner had been constantly supervised when in police or court custody) and open an ACCT. We therefore make the following recommendation:

    **The Governor should ensure that when prisoners meet the criteria for constant supervision, a documented multi-disciplinary conversation takes place to determine the appropriate level of ACCT observations if they are not to be subject to constant supervision.**

## ACCT checks by the OSG

61. The OSG did not complete the ACCT checks as he should have on the night that Mr Olgun died and falsified the record. He was convicted of misconduct in a public office. We make no further recommendation.

## Use of interpretation services

62. Mr Olgun was a Turkish national and his first language was not English. The police had waited four hours for the arrival of an interpreter before they interviewed him. After Mr Olgun's arrival at Hewell, staff do not appear to have considered the use of interpretation services.

63. The nurse said that Mr Olgun could speak and understand English well. However, he also reflected that Mr Olgun was not clear about his arrest or why he had cut himself. The nurse felt he could not understand the cause of Mr Olgun's actions. An officer said that Mr Olgun gave one-word answers which may have been due to his limited command of English. These interactions were the best opportunity to properly gauge Mr Olgun's risk to himself and given his high number of risk factors, best practice would have been to have used The Big Word translation service.

64. The lack of use of interpreting services has not been an issue which we have raised in any of our investigations at Hewell since the death of Mr Olgun. We have recently made a national recommendation that the Prison Service introduce a standardised policy to help staff assess a prisoner's English language ability and inform the use of interpreting services. HMPPS have yet to respond to this. We make no further recommendation in this case.

## Clinical care

65. The clinical reviewer concluded that the clinical care Mr Olgun received was equivalent to that he would have received in the community.

## Emergency response

66. PSI 03/2013, *Medical Emergency Response Codes*, requires prisons to have a medical emergency response code protocol, which should ensure that staff call an appropriate code to summon help immediately and to ensure an ambulance is also requested at once. HMP Hewell uses two emergency codes, code red (which indicates heavy loss of blood) and code blue.

67. Neither the OSG nor the CM who first got to Mr Olgun's cell radioed a code blue. The nurse who arrived at the cell four minutes later radioed the code blue which led to the control room requesting an ambulance. Therefore the lack of calling a code blue led to a delay in calling the ambulance, as well as the attending nurse not being aware that there was an emergency.

68. Due to the long suspension of this investigation, we do not know why the initial staff at the cell did not call a code blue. However, we last made a recommendation about this issue following a death in 2021 after which staff received additional reminders and training. The lack of calling an emergency code has not come up in any of the six investigations we have completed following deaths at the prison since then. We therefore do not regard it as a systemic issue and make no recommendation.

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