



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP Blantyre
House on 28 June 2013**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man, while a prisoner at HMP Blantyre House, who was found hanging in his room on 28 June 2013. The man was 58 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by a senior investigator. A doctor reviewed the clinical care the man received at the prison. Blantyre House cooperated fully with the investigation.

The man had been in prison since September 2000. In December 2006 and June 2009, he committed serious acts of self-harm, citing the reason as his lack of progression to open conditions.

During the late morning of 28 June, an officer delivering mail for the man discovered him hanging in his room. Staff initially decided not to attempt resuscitation, but the ambulance service advised them to do so.

There were suggestions that the man might have been involved in trading illicit substances and also that he was in debt. We have been unable to verify whether this was the case. Eleven days before his death the man was briefly admitted to hospital after injuries which he said he had got by falling on the stairs. When he returned from hospital a manager discussed with him whether anyone else had been involved or if he felt threatened. The man insisted that he felt safe and denied any drug misuse. He was subsequently charged with theft from another prisoner's locker and the incident was rumoured to have arisen from drug dealing. The disciplinary charge was outstanding at the time of his death and the man's progress to release had also been stalled because of concern about his conduct on community placements.

We cannot know what caused the man's actions although, as had happened previously, he may have reacted badly to the stall in his progress towards release. The apparent level of drug use at Blantyre House and associated violence is disturbing but the investigation has not found evidence that the man's death was due to bullying.

While I am satisfied that staff at Blantyre House could not reasonably have foreseen or prevented the man's actions, I am concerned that the emergency response was deficient and there was a delay in beginning cardiopulmonary resuscitation and in calling an ambulance. This is the first death at Blantyre House since my office began investigating deaths in prisons in 2004 and I recognise that the staff have little experience of emergencies of this nature. Nevertheless, it is important that all prison staff understand what is required in an emergency and are confident about handling such incidents when they arise.

The version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

February 2014

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SUMMARY

1. The man had been in prison since 7 September 2000. He was sentenced to life imprisonment for robbery in December 2000 with a minimum period to serve of ten years. He arrived at Blantyre House on 24 August 2012, after serving time in a number of other prisons.
2. The man had made two previous suicide attempts in prison. In December 2006 he had set fire to his room and in June 2009 he had cut his throat. Each time, he explained that his actions were a response to frustration at the length of his sentence and his inability to progress to open conditions.
3. Several security intelligence reports submitted shortly before the man's death and some from previous prisons over a number of years, implicated him in using or trading Spice, a form of synthetic cannabis, but no firm evidence of his involvement had been found.
4. On 17 June 2013, the man was admitted to hospital after falling down the stairs in his accommodation block at the prison. While he was in hospital, it was alleged that he had removed items from another prisoner's locker and there were rumours that it was connected to a drug debt. When he returned to Blantyre House the next evening, he told an operational manager that no one else had been involved in the accident, he had not been under the influence of any substances and he felt safe. Closed circuit television footage indicated that the man had taken property from the other prisoner's locker and he was charged with a disciplinary offence. The hearing was postponed while the man sought legal advice and was not concluded before his death.
5. On 28 June, a prisoner in a neighbouring room heard loud bangs from the man's room between 8.30am and 8.50am. The man told him that he kept falling over. Another prisoner saw him at around 9.00am and a prisoner with whom he was close friends said he had seen him twice that morning and had talked to him briefly at approximately 10.30.
6. At around 10.55am, an officer delivering mail to the man's room discovered him hanging from the light fitting in his room and rang a general alarm. No emergency code was used and staff who first attended were initially unaware of the nature and location of the emergency. At first, a nurse decided not to attempt resuscitation but began when the ambulance service advised her to do so. Paramedics arrived at 11.07 and took over the man's care. The attempts to resuscitate him were unsuccessful and he was pronounced dead at 11.57am.
7. The investigation found that current national instructions for emergency incidents and the use of emergency codes were not followed. We consider that attempts at cardiopulmonary resuscitation should have begun as soon as the man was found.

THE INVESTIGATION PROCESS

8. The investigator issued notices at HMP Blantyre House, informing staff and prisoners of the investigation and asking anyone who had relevant information to contact him. No one responded.
9. NHS England commissioned a doctor to review the man's clinical care in prison.
10. The investigator visited Blantyre House on 2 July. He met the Governor and spoke to staff involved in the man's care and to prisoners who lived in the rooms near the man. He obtained copies of the man's relevant prison and medical records. The investigator interviewed staff and prisoners at Blantyre House on 20 August, 11 and 23 September. He also interviewed a prisoner who had transferred to HMP Elmley. The investigator gave feedback to the deputy governor about the initial findings of the investigation and followed this up in writing. At the draft report stage the National Offender Management Service (NOMS) responded to the recommendations. That response is included below the recommendations
11. HM Coroner for North West Kent provided the results of the post-mortem examination. A copy of this report has been sent to the Coroner.
12. One of the Ombudsman's family liaison officers contacted the man's family to explain the purpose of the investigation and invite them to raise relevant matters they wished the investigation to cover. His family did not have any questions for the investigation to consider. The man's family received a copy of the draft report. They did not make any comments.

HMP BLANTYRE HOUSE

13. HMP Blantyre House is a resettlement prison in Kent for around 120 adult men. Oxleas NHS Foundation Trust provides health services at the prison. There are nurses during normal working hours and doctors from a local practice run surgeries two days a week.

HM Inspectorate of Prisons

14. The Inspectorate's last published report on Blantyre House was issued in July 2010. Inspectors found that it remained an exceptional, specialist resettlement prison. There had been no recorded acts of self-harm for over a year and suicide and self-harm prevention procedures had been used only once in the previous two years. A further inspection took place in September 2013, but the report has not yet been published.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In their annual report for the period ending in June 2013, the IMB were concerned were critical of the failure to hold regular safer custody meetings and believed that an increase in bullying and violence was attributable to an increasing drug culture in the prison and debts arising from the use of "Spice", a synthetic form of cannabis. The IMB was concerned that in spite of serious safer custody incidents including bullying and violence, no prisoners had been monitored under Prison Service suicide and self-harm prevention procedures.

Previous deaths at Blantyre House

16. This was the first death at Blantyre House since the Ombudsman's office began investigating deaths in custody in 2004.

KEY EVENTS

17. The man was born in 1954. He was remanded into custody at HMP Woodhill on 7 September 2000. This was not his first time in prison. He had a long history of offending and had 25 previous convictions since 1969. On 11 December 2000, the man was sentenced to life imprisonment for robbery, with a minimum period to serve of ten years. He spent time in a number of prisons.
18. At HMP Wellingborough on 11 December 2006, the man set fire to his room and received treatment in hospital for smoke inhalation. He said that he had tried to kill himself as he could no longer cope with being in prison and not progressing to open conditions. Prison staff monitored him under Prison Service suicide and self-harm prevention procedures. His partner died during this period and he continued to be monitored until March 2007. The man received care from the prison's mental health team and a psychiatrist diagnosed depression.
19. On 1 June 2009, the man attempted to cut his throat and again attributed his actions to his failure to progress to an open prison. He was treated in hospital and was monitored him under the suicide and self-harm prevention procedures for just over a month. He was prescribed an antidepressant.
20. On 16 March 2011, the man transferred to HMP Ford, an open prison. On 12 August, he failed to return from day release and the next day, he was returned to closed conditions at HMP Chelmsford.
21. The man moved to Blantyre House on 24 August 2012. At an initial health screen he told Nurse N that 2005 to 2006 had been a bad time for him. He was open about his self-harm during this period but assured the nurse that it had been a long time ago and he had no current thoughts of self-harm. There was no reference to the suicide attempt in 2009. Nurse N told the investigator that she had spent between 20 and 30 minutes with the man, in which she had carried out a risk assessment and there were no other health concerns.
22. Each prisoner at Blantyre House has a personal officer as the first point of contact for advice and support. On 4 September, Officer A introduced himself as the man's personal officer and they discussed his sentence progression. The man later became part of the prison's Insider team, who offer support to other prisoners. Officer A recorded that he used his skills as an Insider extremely well.
23. The man worked in the kitchens at Blantyre House. The catering manager described him as a committed and valuable member of staff. In January 2013, there were concerns about his timekeeping at work and poor attendance and disruptive behaviour in education classes but his attitude later improved. In March, the man started a community work placement at a local charity shop but the manager considered him unsuitable, owing to his attitude and appearance and the placement ended after a month.

24. On 6 May, the man's personal officer at that time wrote that he was continuing to frustrate staff with his "couldn't care less attitude" and he did not seem to understand that he was unlikely to progress to release if he did not change. The personal officer noted that he had previously spoken to the man about this.
25. On 15 May, the man's progression to paid work and overnight release was suspended until he could demonstrate, over a sustained period, that he was able to manage a community work placement with no negative comments about his performance. Two provisional places had been booked at approved premises to enable the man to be released for supervision in the community, but managers considered that as the man had not complied with the requirements of Blantyre House, he was unsuitable for overnight release. He was allowed to continue to have town visits on day release as this would give him the opportunity to gain community work experience. The personal officer subsequently noted that the man continued to work well in the kitchen and was waiting to start community work when a placement became available.
26. Early on 17 June, the man fell on the stairs in his houseblock and an ambulance took him to a local hospital at around 7.45am. The man was discharged from hospital the next day. His discharge summary stated that he had fallen down a number of concrete steps landing face down in an unwitnessed fall. There were no visible signs of injury but the man had a tender and painful back.
27. While the man was in hospital, another prisoner reported to staff that the man had stolen money from the locker of another prisoner, Mr P. Close circuit television (CCTV) footage showed that at around 9.48am on 15 June, just before the man was due to leave Blantyre House for a town visit, he used a key to open a locker belonging to another prisoner, Mr P. He put some items in his pockets.
28. A custodial manager interviewed Mr P who denied that there had been an altercation between him and the man. After further investigation, the custodial manager reported that Mr P had apparently allowed the man access to his locker to take £20 as a payment for 'Spice' but he had allegedly taken all the money (approx £85). An empty packet of Spice had been found in the man's room. An operational manager responsible for safer custody reviewed the CCTV evidence and was satisfied that there was enough evidence to lay a disciplinary charge against the man.
29. The operational manager interviewed the man about his fall when he returned to Blantyre House. The man explained that he was on his way down the stairs and had slipped after turning to go back up to collect something he had forgotten. He was adamant that he had not been pushed or tripped and that he was not in debt to or being threatened by other prisoners. He denied being under the influence of any substances when he fell. He said he had no problems at the prison and felt safe. The man said that he did not take drugs and the empty Spice packet found in his room was not his and someone else must have put it there. The operational manager told the investigator that the

man was relaxed, maintained good eye contact and gave confident answers to his questions.

30. The operational manager revoked the man's and Mr P's authorisations for temporary release until the matter was fully investigated. He believed that because of the impending investigation, the man was at increased risk of absconding while on temporary release. He did not consider the man was at risk of suicide or self-harm.
31. In a statement to the investigator, the deputy governor said that as the security manager he was aware of security information reports from several previous prisons over a number of years and eight from Blantyre House between February and June 2013, which implicated the man in using and trafficking Spice. However, searches of his room, drug tests and full searches, found no proof of this.
32. On 19 June, the man was formally charged with an offence under Prison Rules for taking money from Mr P's locker. The deputy governor opened the hearing the same day but agreed to postpone it for seven days to allow the man to seek legal advice.
33. A review board had been planned on 26 June, to consider whether the man's opportunity for overnight release and progression to paid work should be reinstated, but a decision was deferred until after outcome of the disciplinary hearing. Officer A informed the man of this decision. He told the investigator that the man probably knew that as a result of his poor behaviour, he was likely to be sent back to closed conditions. He said the man did not display any emotion when he gave him the information and there was nothing in his behaviour which caused him concern.
34. The catering manager said that the man had been a little quieter but his work performance had improved.
35. The deputy governor informed the man on 24 June, that the disciplinary hearing would not take place on the Wednesday, as scheduled, but he hoped to do it by the end of the week. The man said that his solicitor intended to ask for an extension anyway and he seemed content. The deputy governor said his contact with the man was amiable and there was no indication that he seemed stressed. The deputy governor did not consider the man to be at risk of suicide or self-harm at any time at Blantyre House.
36. The operational manager said he saw the man leaving the kitchen on the afternoon of 27 June. They spoke briefly to each other and exchanged pleasantries. The operational manager had no concerns about him.
37. At approximately 7.30am on 28 June, Officer B conducted a roll check (a count of prisoners, which normally takes place at the beginning and end of the night shift) and saw the man in his room.

38. Mr R lived in the room next to the man's and worked at night. He said that as he was returning to his room at around 5.45am, the man was going to make a cup of tea and they had a short conversation. He then went to bed and heard nothing until officers woke him up to tell him about the man's death. Mr R said the man was popular and sometimes came to his room for peace and quiet, to get away from all the people that were around him. He believed that the man was involved in the drug culture and that he liked Spice and other substances. Mr R had heard that the man might have been in debt due to this but that this was hearsay.
39. Mr S, the prisoner who lived in the room on the other side, told the investigator that he was often awake during the night and fell asleep at around 7.30am each morning. At around 8.30am, he was woken up by a loud bang. When he called out to ask what had happened, the man apologised and said that he was sorry to keep falling over and had a sore toe. Mr S went back to sleep but heard two further bangs, which disturbed his sleep. He shouted to the man again after the third bang. A little later, he heard a noise like a rumble but did not notice the time. He thought it might have been about 8.50am and was certain it was after the roll check. He did not say anything to the man on this occasion. Mr S said that, with hindsight, he thought that the man had been ripping the light from the ceiling to get to the joist.
40. Prison records state that Mr T, another prisoner, saw the man at 9.00am and said good morning to him.
41. The investigator also interviewed, Mr U, a close friend of the man who lived in a nearby room. Mr U described the man as a sociable man who was never on his own and always had people around him. He said he saw the man twice on the morning of his death, once when he was on his way to the offender management unit when the man was going to the urn with a cup in his hand. He then said he saw him on his way back at about 10.30am and told the man that he would visit him shortly.
42. At around 10.55am, Officer C went into the man's room to deliver his mail. He found the man hanging, suspended by a knotted neck tie, joined to what appeared to be a belt, tied around the light fitting. Officer C activated a general alarm bell outside the room. (This gives a general location, but does not indicate a particular room.)
43. About a minute later, Officer A, who had heard the alarm, ran along the landing. He said he had expected that two prisoners were fighting. As he was about to run past the room, Officer C called him in and gave him his anti-ligature tool. Officer A climbed onto the bed and cut the ligature while Officer C supported the man's body. They placed the man onto the bed.
44. Officer A then ran downstairs to get a nurse from the healthcare department. While he was doing this, Officer C called the control room and asked them to call an ambulance. (The ambulance service records show that the call was received at 11.02am.) Officer A accompanied the Nurse N back to the room but remained outside while she went in. When she arrived, Officer C asked if

he should use the defibrillator. He said that Nurse N indicated that there was no need. Officer C telephoned the gate lodge to find out if the ambulance was on its way. The staff at the gate asked if cardiopulmonary resuscitation (CPR) had started as the ambulance service had asked that this should be done. Officer C said it had not and then went back to the room, placed the man on the floor and he and Nurse N started resuscitation.

45. When interviewed, Nurse N said that she was in the healthcare department when she heard the alarm. She called the gate staff to find out where the incident was and whether she was needed. Initially they did not know, but it then it became apparent that it was North 7. She took the emergency bag and as she left, Officer A told her to go to the North spur. Nurse N had no idea of the nature of the emergency and expected to treat either a prisoner with an existing medical condition or, because of recent incidents, someone who had been slashed. (There had been two violent incidents at Blantyre House in December 2012 and April 2013.)
46. Nurse N said that when she examined the man he was very cold to the touch, his hands and feet were purple but he was not stiff. There was sputum on his abdomen which was dry and crystallised. She loosened the ligature, but left it around his neck in case it was needed for evidence and used a stethoscope to check for a heartbeat, but there was none. After she finished her assessment, Nurse N decided not to try to revive the man. However, a short time later, Officer C told her that the ambulance service had instructed them to give cardiopulmonary resuscitation (CPR). Nurse N tried to give air through an oxygen mask while Officer C gave chest compressions. The man's airway was obstructed and she realised that the likely cause was an indentation made by the ligature. The resuscitation attempts continued until 11.07am, when a paramedic arrived.
47. The paramedic took over from Nurse N while Officer C continued chest compressions. Another prison nurse arrived at around 11.15am and assisted with the CPR. The paramedic tried to give the man oxygen and they were joined by an ambulance crew five minutes later. One took over from Officer C and the other assisted the first paramedic. The paramedic took the man's temperature which was 30 degrees (normal temperature is between 36.1 to 37.2 degrees). Approximately five minutes after the second crew arrived, another ambulance crew arrived. They continued to attempt resuscitation, but the senior paramedic pronounced the man dead at 11.57am.
48. Another broken noose made of plaited bed sheets was found in the dustbin in the man's room. The police surmised that he might have used this in an initial attempt when the man's neighbour had heard a loud bang from his room.
49. During the afternoon of 28 June, the Governor of Blantyre House assembled all the prisoners in the prison canteen to inform them of the man's death. Those who were at work and community placements were informed individually when they returned to the prison. Prisoners were offered support and the opportunity to speak to a member of the chaplaincy.

50. A debrief for the staff involved was held later that day. No specific issues were identified and the staff were offered the support of the prison's care team.
51. The prison had no details of the man's next of kin as he had lost contact with his family and no one had visited him in prison for a number of years. The police then found contact details for the man's mother. The deputy governor at HMP East Sutton Park acted as the prison's family liaison officer and accompanied the police to her home that day, to notify her of his death. However, no one was at home. On 2 July, the police found an address for the man's sister and the Governor wrote to offer his condolences. The prison held a memorial service on 14 July. The deputy governor at HMP East Sutton Park maintained contact with the man's family and offered support. She ensured all his belongings were returned and, in line with national policy, the prison offered financial assistance towards the cost of the man's funeral, which took place on 24 July 2013.

ISSUES

Medical care

52. The man had no serious health conditions and the clinical reviewer is satisfied that healthcare staff at Blantyre House dealt appropriately with any reported illnesses. The clinical reviewer made several recommendations in her review which is annexed to this report and which the Head of Healthcare will need to consider.

Risk of self-harm

53. The man had twice previously tried to kill himself in prison. In 2006, by setting fire to his room and slashing his throat in 2009. On both occasions, he was monitored under suicide and self-harm prevention procedures and received mental health support. At his health screen in August 2012, when he arrived at Blantyre House, the man discussed his previous self-harm in 2006 and explained that it had been triggered by specific issues at that time. Nurse N, who conducted the health screen, was satisfied that there was no risk of self-harm at the time and took no further action.
54. The deputy governor at Blantyre House told the investigator that, although the man was involved in a disciplinary hearing, he did not have any recent history of self-harm or suicide. The deputy governor said he had extensive experience of dealing with prisoners who had self-harmed and did not think the man displayed any signs of suicidal behaviour. The deputy governor felt that the man had been supported by staff after he was informed of the disciplinary action and no one thought him at risk of self-harm or suicide.
55. Although staff were concerned about the man's motivation, his poor performance at work, his appearance and an alleged act of theft, they did not link these concerns to past history of self-harm or view them as precursors or possible triggers for future acts of self-harm.
56. The clinical reviewer commented that the man's medical history indicated that he would become suicidal and commit acts of self-harm when he became hopeless. The man had not asked for help before his previous attempts at self-harm and staff and other prisoners had not noticed any deterioration in his mental state before his actions on 28 June 2013. The clinical reviewer considered the adverse events that might have lead to his death, such as the loss of his community placement, the review board of his resettlement day release and the pending disciplinary hearing relating to the allegation of theft. She concluded that in view of the man's history, it was unlikely that staff and prisoners would have detected changes in his mental health unless he had spoken about it. We are satisfied that staff at the prison could not have been expected to predict the man's actions.

The possibility of bullying

57. Intelligence received by the prison between February and June 2013, suggested that the man might have been involved in supplying and/or using Spice. Several of the man's previous prisons had also recorded suspicion of him trading Spice over number of years. However, searches of the man and his room as well as drug tests failed to provide any substantive evidence of illicit drug use or trading. After his death, it was also suggested that he might have been in debt because of his use of Spice.
58. Eleven days before his death, the man had injured himself in an unwitnessed fall. While he was in hospital, it was alleged that he had taken money from the locker of another prisoner, Mr P, two days before he said he fell on the stairs. When questioned by prison managers, Mr P denied that there had been any altercation between them and there is no evidence that anyone else was involved in the incident. After the man was discharged from hospital and returned to the prison, the operational manager asked whether he felt safe and explicitly asked whether he was under the influence of drugs when he fell, if he was in debt and whether anyone had threatened him. The man said he felt safe and denied the use of drugs or being in debt.
59. Neither staff nor other prisoners had any concerns about the man in the days leading up to his death and no one indicated that he had felt threatened. It is a concern that there had been a number of incidents of violence at the prison, apparently related to drugs and the 2013 Independent Monitoring Board annual report highlighted that debts for drugs had led to bullying and intimidation at the prison. We recognise that prison culture is such that it is unlikely that the man would have reported any of these issues to staff, but we are satisfied that staff did what they could to explore the circumstances of his fall with him and gave him the opportunity to report any problems, such as bullying, that might have led to it. We have found no evidence that the man's death was due to bullying.

Emergency response codes

60. Officer C discovered the man hanging in his room at around 10.55am. He pressed a general alarm and, with the assistance of Officer A, cut him down. While Officer A went to get a nurse, Officer C radioed to ask the prison control room to call an ambulance. Records show that an ambulance was not called until 11.02am, seven minutes after the man was found hanging. The nurse heard the general alarm but did not initially know the location of the incident and was unaware that the prisoner was unconscious or what the nature of the incident was. Nevertheless, she took the emergency bag with her, but this did not contain a defibrillator.
64. The first paramedic arrived at the room at 11.07am, five minutes after being called and brought a defibrillator and oxygen. Two further paramedic teams attended a few minutes later. They tried to resuscitate the man for 50 minutes but their attempts were unsuccessful.

PSI 03/2013 *Medical Emergency Response Codes*, issued in February 2013,

contains mandatory instructions for governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies.

65. The officers who found the man did not use an emergency response code but pressed a general alarm bell and sought other staff for assistance. Officer C did not use an emergency code when he called to request an ambulance. This meant that the other staff who responded were not immediately alerted to the nature of the emergency and there was a considerable delay of seven minutes until an ambulance was called.
66. A *Joint Notice to Staff* was issued at Blantyre House on 28 February 2013, setting out a protocol for staff to follow when responding to a medical emergency. We are not satisfied that the protocol is fully compliant with PSI 03/2013. Although, it lists a code system based on that in the national instructions and sets out the required responses, it does not explicitly instruct staff to call an emergency code in a medical emergency, which was a major failure in this case and led to a delay in calling an ambulance. It also meant that a defibrillator was not brought and used. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Blantyre House has a Medical Emergency Response Code protocol which:

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency;**
- **Ensures staff called to the scene bring the relevant equipment; and**
- **Ensures there are no delays in calling, directing or discharging ambulances.**

Resuscitation

67. When Nurse N reached the room, she found that the man was cold to touch and the sputum on his chest was dry. She found no signs of life and decided not to attempt resuscitation. It was not till some minutes later, on the advice of the ambulance service, that she and Officer C started CPR.
68. The clinical reviewer points out that the general advice given to officers and healthcare staff in prisons is to start CPR on individuals suspected to be dead until death is declared by a senior paramedic or a doctor. We agree that this should happen unless there are clear signs of death such as the presence of rigor mortis, which would indicate that resuscitation would be futile.

69. We do not know when the man took his life, but there is credible evidence that he had been seen alive around twenty minutes before he was found. It is vital that if a person is unconscious cardiopulmonary resuscitation is started as soon as possible to improve the chances of survival unless there are clear signs of death such as the onset of rigor mortis. None of the staff who saw the man indicated that rigor mortis was evident. We acknowledge that at a prison such as Blantyre House staff do not often need to use resuscitation skills but for that reason it is important that they understand what is required in such an emergency. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff working in the prison receive sufficient guidance and training to understand the benefits of immediate cardiopulmonary resuscitation for a prisoner who is not breathing and that CPR should be started, unless there is clear evidence that it would be futile in the circumstances.

RECOMMENDATIONS

1. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Blantyre House has a Medical Emergency Response Code protocol which:
 - Provides guidance to staff on efficiently communicating the nature of a medical emergency;
 - Ensures staff called to the scene bring the relevant equipment; and
 - Ensures there are no delays in calling, directing or discharging ambulances.

2. The Governor and Head of Healthcare should ensure that staff working in the prison receive sufficient guidance and training to understand the benefits of immediate cardiopulmonary resuscitation for a prisoner who is not breathing and that CPR should be started, unless there is clear evidence that it would be futile in the circumstances.

ACTION PLAN: The man at HMP Blantyre House on 28 June 2013

No	Recommendation	Accepted/Not accepted	Response	Target date for completion
1	<p>The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Blantyre House has a Medical Emergency Response Code protocol which:</p> <p>a) Provides guidance to staff on efficiently communicating the nature of a medical emergency;</p> <p>b) Ensures staff called to the scene bring the relevant equipment; and</p> <p>c) Ensures there are no delays in calling, directing or discharging ambulances.</p>	Accepted	<p>The existing Notice to Staff will be incorporated into a new policy document that will be published to all staff and located in the Policy Documents folder on the Z drive.</p> <p>It will contain clear step by step instructions on the responsibilities of:</p> <p>First on Scene Gate staff Orderly Officers Healthcare staff</p> <p>Posters will be designed and displayed in prisoner and staff areas that identify the medical codes and immediate response actions in the event of a medical emergency.</p> <p>The policy will contain clear instructions to healthcare professionals on the level of equipment required for each designated response code.</p>	Responsible Manager: Head of Residence & Safety 31/1/2014
2	<p>The Governor and Head of Healthcare should ensure that staff working in the prison receive sufficient guidance and training to understand the benefits of</p>	Accepted	<p>As part of the implementation of PSI 01/2014 we will implement a programme of First Aid At Work training for all CM's initially as they provide the Orderly Officer cover at Blantyre House for a full 24hour</p>	<p>Health & Safety Manager 31/1/2014</p> <p>Responsible Manager: Head of Residence & Safety</p>

	<p>immediate cardiopulmonary resuscitation for a prisoner who is not breathing and that CPR should be started, unless there is clear evidence that it would be futile in the circumstances.</p>		<p>period. This will ensure the provision of a trained first aider, qualified in CPR at all times.</p> <p>The emergency response policy and posters (see Rec 1 above) will incorporate clear guidance to all staff on the need for immediate CPR and the designated persons mandated to authorise the cessation or non application of CPR.</p> <p>This point will be reinforced by a specific mention of this when the policy is published.</p>	<p>31/1/14</p>
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