PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Belmarsh in April 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 who was found dead in his cell in April 2013 at HMP Belmarsh. He was 37 years old. I offer my condolences to his family and friends.

A clinical review of the medical treatment the man received in prison was conducted. The prison cooperated fully with this investigation.

The man had a history of mental health problems and was diagnosed with gender dysphoria in 2009. In 2010, he pushed a friend under a tube train and was remanded into custody. He decided not to continue with treatment for gender dysphoria. He was monitored under Prison Service suicide and self-harm prevention procedures in the inpatient unit at Belmarsh between November 2010 and April 2011, when he was transferred to a secure hospital for assessment. While there, he was treated with antipsychotic medication and his mental health stabilised. He was convicted of manslaughter by reason of diminished responsibility. He was sentenced to life imprisonment in December 2011 and returned to Belmarsh.

This investigation has identified some concerns about the man's mental health care during his second period at Belmarsh. The prescription he was given when discharged from hospital was not checked and he did not receive an antidepressant and a vitamin supplement. He was under the sole care of the prison psychiatrist and no other member of the mental health team was given responsibility for his ongoing care. An administrative error meant he was not seen at all between January and September 2012, when the psychiatrist re-established contact. In the weeks before his death, his antipsychotic medication was reduced rapidly at his request, but without any increased monitoring. We consider that his aftercare after being discharged from hospital was unsatisfactory and the clinical reviewer concludes that his clinical care was not equivalent to that he would have expected to receive in the community.

The man was found dead in his cell at on a morning in April and an earlier roll check had not noticed anything amiss. It was clear that he had planned his actions as he had put a bag over his head, secured it with a sheet and tied both of his hands to the metal bed frame. Although rigor mortis was clearly present, resuscitation was attempted until paramedics arrived and pronounced death.

The man had complex mental health issues and was difficult to communicate with. Those who came into contact with him most had not noticed any change in his behaviour before his death. While he had a number of factors which would always have meant he was at risk of suicide, I consider it would have been very difficult for prison staff to have foreseen or prevented his actions.

This 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 was born in Sri Lanka. He moved to the UK in 2000 and worked as a graphic designer. In 2007, his father died suddenly and his mother committed suicide two weeks later. He had a history of mental illness from his teens. In 2009, he was diagnosed with gender dysphoria and began hormone treatment for gender reassignment in early 2010. He was treated for depression but did not always take his medication. He became friends with the victim of his crime in 2009. On 25 October 2010, he pushed his friend under a tube train. He was arrested at the station.

2. The man was remanded to HMP Wandsworth and suicide and self-harm prevention procedures (known as ACCT) began. He transferred to HMP Belmarsh on 1 November still being monitored under ACCT procedures. Because of his vulnerability and poor mental health, he lived in the prison's inpatient unit. In January 2011, he tied a sheet round his neck and repeatedly ran head first into a wall. He said he was depressed and anxious about his trial. He was referred to Three Bridges Regional Secure Unit (a medium secure mental health hospital) and accepted on their waiting list in February 2011.

3. The man transferred to Three Bridges on 14 April 2011. He was treated with olanzapine (an antipsychotic) and citalopram (an antidepressant) and his mental health improved. A Section 117 meeting (to discuss aftercare for patients detained under the Mental Health Act when they are discharged from hospital) on 15 December 2011 decided that he did not need a hospital order. On 22 December 2011, he was convicted of manslaughter by reason of diminished responsibility and sentenced to life imprisonment. He returned to Belmarsh.

4. On 3 January 2012, the man was discussed at the weekly multi-disciplinary mental health meeting, which decided that the prison psychiatrist would review him every two months in his out-patient clinic. His prescription from Three Bridges was not verified when he arrived back at Belmarsh and he did not get the antidepressant medication he had been prescribed at the hospital. Belmarsh subsequently requested and received details of his treatment and prescription from Three Bridges but no one seems to have read it or changed his medication as a result. He did not have any appointments with the psychiatrist between January and September 2012 despite the agreement to hold reviews every two months.

5. The man lived on a standard wing at Belmarsh and did not mix with other prisoners or speak to staff much. He worked as a foreign national orderly for two months but was not suited to the interaction with other prisoners the job required. After this he attended an art class in education. He attended the weekly Hindu service. He did not always take his medication as prescribed and, at his request, the prison psychiatrist reduced the dose three times between September 2012 and March 2013. None of the staff or prisoners who came into contact with him noticed any change in his demeanour during this second period in Belmarsh.

6. One morning in April 2013, an officer discovered the man dead on his bed. He had put a plastic bag over his head and tied both of his wrists to the metal bed frame. Although rigor mortis was present staff attempted to resuscitate him until paramedics arrived and pronounced him dead. While it did not affect the outcome in this case, an ambulance was not called immediately when the emergency code was used, as Prison Service instructions require, resulting in a brief delay. A hot debrief for staff involved in the resuscitation attempt did not take place.

7. We make recommendations about aftercare for prisoners returning from mental health secure units, the resuscitation of prisoners in rigor mortis, night roll checks procedures, telephoning for ambulances and the need for hot debriefs to support staff after a traumatic event.

THE INVESTIGATION PROCESS

8. The investigator issued notices about the investigation to staff and prisoners at HMP Belmarsh inviting anyone with information to contact her. No one came forward.

9. The investigator visited Belmarsh on 17 April and met the Head of Safer Custody and Violence Reduction. She spoke to representatives of the Independent Monitoring Board, the prison's family liaison officer and interviewed two prisoners. She visited the man's cell and spoke to the house block manager. She collected copies of his prison record and other relevant paperwork.

10. The investigator spoke to a Detective Inspector of the Metropolitan Police, who supplied a copy of the police investigation report.

11. NHS England (London region) appointed a clinical reviewer to review the man's clinical care at the prison. The investigator and clinical reviewer jointly interviewed three members of staff and spoke to a psychiatrist at Three Bridges Regional Secure Unit. The investigator interviewed a further seven members of staff and three prisoners. She gave written and verbal feedback to the prison liaison officer and the deputy governor during the investigation.

12. One of our family liaison officers informed the man's cousin and her husband about the investigation. They asked why he had been allowed to have a plastic bag and shoelaces and wanted more information about what happened the night of his death. They were concerned that he might have been bullied or beaten in prison.

13. The man was not regarded as at risk of suicide or self-harm during his second period in Belmarsh between December 2011 and April 2013. His possessions were therefore not restricted. The bag he had was the standard issue plastic bag in which prisoners receive their weekly orders from the prison shop. There was no reason to restrict his possessions such as shoelaces. The investigator could find no evidence that he had been bullied, threatened or attacked at Belmarsh. A full account of what is known about the night he died is contained in the key events section.

14. The man's family were sent a copy of our draft report but made no comments.

HMP BELMARSH

15. HMP Belmarsh is a high security and local prison serving the courts of South East London and South West Essex. It holds up to 933 adult male prisoners. A private company provides healthcare services (previously Harmoni, which is now part of Care UK).

16. There are approximately 200 foreign national prisoners at Belmarsh. A full-time foreign national co-ordinator runs a bi-weekly forum for foreign national prisoners.

Her Majesty's Inspectorate of Prisons

17. Her Majesty's Inspectorate of Prisons (HMIP) last inspected Belmarsh in April 2011. Inspectors acknowledged that Belmarsh is a large and complex prison, which had to meet high security standards while the majority of prisoners are lower risk.

18. Inspectors found that support for foreign nationals was good and a committed team ran several support workshops. Prisoner representatives offered a good service.

19. HMIP reported that staff-prisoner relations varied between units and the personal officer scheme was generally ineffective. Most prisoners were not aware of their personal officer and few found them helpful. Entries on prisoners records did not reflect meaningful engagement and were often less frequent that required. Many staff said that they did not have the time to complete their responsibilities as personal officers. The frequency of cell moves resulted in inconsistencies.

20. HMIP noted that the mental health in-reach team was led by a full-time consultant psychiatrist and each member of the team carried a caseload with support from a psychiatrist. Primary mental health services were limited which meant that most prisoners with mental health needs were supported by the mental health in-reach team.

Independent Monitoring Board

21. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. The IMB annual report for 2011-12 said the prison's inter-departmental approach to managing foreign national prisoners was impressive.

22. The IMB was concerned about the impact of staffing shortages on the delivery of healthcare services. The IMB also noted that meeting the needs of prisoners with a wide range of mental health problems was a major challenge for Belmarsh.

Previous deaths at HMP Belmarsh

23. Since 2010, we have investigated nine deaths at Belmarsh. In one death in 2011, we made a recommendation that relevant staff should be invited to a hot debrief in any future death in custody, a matter we raise again in this report.

KEY EVENTS

24. The man was born in Sri Lanka. He moved to India with his parents when he was nineteen years old to escape the civil war. He lived in India for 15 years and studied graphic design, then moved to the UK in 2000. He took a masters degree and worked full time as a graphic designer. His GP records show a history of depression since 1990. He first came into contact with mental health services in the UK in 2001. His father died suddenly in 2007 and his mother committed suicide two weeks later.

25. In 2005, the man's GP referred him to a psychotherapist to help him address issues about his gender identity. The psychotherapist referred him to a psychiatrist who diagnosed schizoid traits and obsessive/compulsive disorder (OCD). He was prescribed fluoxetine (Prozac) but it increased his anxiety. He lost his job and his house in 2008 due to health problems. After a period of homelessness he was supported back into housing by a homeless charity. He subsequently worked in a museum as a volunteer. He said that he had difficulty concentrating and had issues with his sexuality that made him depressed. He was diagnosed with gender dysphoria in 2009 and began hormone treatment for gender reassignment in early 2010. He was treated for depression but did not always take his medication.

26. In 2009 the man was granted indefinite leave to remain in the UK. He also met the victim of his offence that year and they became friends. On 25 October 2010, his friend accompanied him to his GP and expressed concerns about his mental health. On the way home, he pushed his friend under a tube train. He was arrested at the scene and taken into police custody.

27. On 28 October, the man was remanded to HMP Wandsworth, where he was regarded as vulnerable because of his mental state and his transgender status. An ACCT (Prison Service suicide and self-harm monitoring procedures) was opened. He transferred to HMP Belmarsh on 1 November 2010. A prison doctor saw him the same day and noted that he was under the care of a community mental health team and was receiving hormone treatment for gender reassignment. He said he had family problems and had suffered traumatic experiences. The doctor admitted him to a safer cell (a cell with minimal ligature points) in the prison's inpatient unit. His ACCT remained open and he was watched continuously by a member of staff.

28. On 2 November 2010, the man told a nurse that he had been close to having gender reassignment surgery but was now not taking his hormone treatment. He saw an associate specialist psychiatrist the same day and gave a history of gender dysphoria, depression and "paranoia and social phobia". He said he had no history of attempted suicide or self-harm. The psychiatrist prescribed citalopram (an antidepressant) and referred him to the prison's consultant forensic psychiatrist. The psychiatrist saw him on 14 January 2011. He could not determine whether he had a mental illness and decided to review him again in a month.

29. There are several entries on the man's ACCT record describing him as depressed and very quiet. He told staff that he was depressed about his situation and anxious about his trial. He did not mix very much with other prisoners in the healthcare centre and at first complained about being kept on constant observation and then about having to live in a ward with five other prisoners, which he found noisy and lacking in privacy. He went to prison's therapeutic day care centre and did yoga and art classes. He attended the weekly Hindu service in the prison's multi-faith centre.

30. On 16 January 2011, the man was found with a sheet tied tightly round his neck, running repeatedly head first into his cell door. Staff restrained him to stop him hurting himself further and he was taken to hospital with head and neck injuries. He later said that he had been anxious about his trial and was not sure if he had wanted to kill himself.

31. On 7 February, the forensic psychiatrist reviewed the man. The psychiatrist said that the man (who spoke good English) was difficult to assess due to his barely audible speech but his behaviour in healthcare was increasingly suggestive of mental illness. He said he was not clear about a diagnosis because although there were some features of mental illness there also appeared to be abnormalities within his personality, cultural beliefs and the nature of his gender dysphoria. He said he was not able to assess him fully in prison and believed assessment in a medium secure mental health unit was necessary. The same day he sent a referral to Three Bridges Regional Secure Unit.

32. A consultant forensic psychiatrist from Three Bridges saw the man on 23 February. He wrote to the prison psychiatrist the same day. The psychiatrist said the interview was difficult because of the man's mental state and the fact that at first he was almost mute. His speech was difficult to understand and he often would not answer questions. He said he had not been able to come to any conclusions about a diagnosis. He said that he clearly had complex problems, which might be clinical depression or an underlying psychosis. He thought there were likely to be personality issues as well as gender dysphoria. He put him on the waiting list for transfer to Three Bridges for a period of assessment.

33. The man's ACCT was closed on 15 March 2011 after a period of more stable behaviour but another one was opened on 22 March after he was observed pouring boiling water on his arm and banging his head against the wall. He told the prison psychiatrist that his self-harm was in response to anxiety about his trial and a lack of privacy on the ward. On 14 April, he was transferred to Three Bridges.

34. The consultant forensic psychiatrist said at interview that the man had been paranoid and psychotic at the time of his offence. Much of the work done with him at Three Bridges was centred around keeping him psychologically stable. The psychiatrist said he had entrenched difficulties that nobody had succeeded in dealing with properly. He was treated with olanzapine (an antipsychotic) and his mood stabilised and his ability to communicate

improved greatly. He continued to be prescribed citalopram. The psychiatrist told the investigator that there was no real way to address his problems psychologically and the conclusion of his assessment in Three Bridges was that a hospital order was not required and that he should return to Belmarsh after his trial in December 2011. His prescription for citalopram was changed to sertraline (another antidepressant) after the pharmacist was concerned about the interaction between olanzapine and citalopram.

35. On 15 December, the prison psychiatrist attended a Section 117 meeting (a meeting to discuss aftercare for patients detained under the Mental Health Act when they are discharged from hospital) at Three Bridges. The minutes record a discussion of the man's offence and his plea of diminished responsibility. A hospital order was not considered appropriate. He was described as engaging in the minimum number of activities at Three Bridges and "keeping limited contact with his peers and staff members". His vulnerability and risk of suicide in prison was also discussed. It was noted that he had not displayed suicidal or self-harming behaviour at Three Bridges and had asserted himself if other patients had invaded his personal space or attempted to bully him.

36. The minutes show the man complied with his medication and therapeutic activities. He had not been a management problem. His care plan at Three Bridges was for him to engage in therapeutic activities and it is recorded that he saw this as his main route to recovery. There is no reference in the minutes to on-going care at Belmarsh or any discussion about his medication other than that he was compliant with it.

37. On 22 December 2011, the man was found guilty of manslaughter by reason of diminished responsibility and sentenced to life imprisonment with a minimum time to serve of seven years before he could be considered for release. The trial judge concluded that at the time of the offence he was "suffering from an abnormality of mental functioning arising from a recognised medical condition, whether it is a paranoid psychosis arising from a delusional disorder or paranoid schizophrenia". The same day a warrant of remission to prison was signed on behalf of the Secretary of State for Justice. The warrant stated that a forensic psychiatrist had notified the Ministry of Justice that he no longer required hospital treatment for mental disorder and could be returned to prison. He returned to Belmarsh from court the same day.

38. When the man was discharged from Three Bridges, he was prescribed olanzapine 20 mgs daily, sertraline 50mgs daily and calceous (for a vitamin deficiency). He appeared calm and stable on reception but said he felt vulnerable because he was a transgender prisoner. He was allocated a safer cell in the first night centre pending a mental health review. His first reception health screen recorded that he said he was on olanzapine 20mgs daily. A doctor saw him the same evening. The doctor noted his treatment at Three Bridges. He said he had self-harmed during his previous period at Belmarsh as he was scared because it was his first time in prison. He said he had no current thoughts of suicide or self-harm. The doctor wrote, "On olanzapine 20mg – stable on this dose. No diagnosis for condition yet." He said his

speech was clear. The doctor continued his olanzapine prescription and sent an urgent referral to the mental health in-reach team. There is no mention on the record of sertraline or calceous.

39. On 23 December, a psychiatrist wrote on the man's record that the report by the psychiatrist for the defence had been received by email and scanned into the system. The psychiatrist denoted this entry as a mental health review but it is not clear whether he spoke to the man or whether this was the urgent referral the doctor had requested.

40. The man's offender supervisor interviewed him on 28 December 2011. The man told him that he had not been diagnosed with any specific mental illness but had been prescribed antipsychotic medication. The offender supervisor was aware that he had previously been on an open ACCT at Belmarsh. He said he was not currently suicidal and had no thoughts of suicide or self-harm.

41. On 30 December, Belmarsh received the man's care plan from Three Bridges which noted his treatment with olanzapine and citalopram. The document was scanned into his medical record.

42. On 3 January, the man was discussed at the weekly multi-disciplinary mental health team meeting. At interview, the prison psychiatrist said that it was decided at that meeting that he would review him periodically as an out-patient. There are no minutes of the meeting and the medical record simply records "medical follow up – for periodic review". He told the investigator that it was decided he would take sole charge of him rather than involve the mental health in-reach team as he was familiar with him.

43. The prison psychiatrist saw the man later the same afternoon with the specialist psychiatrist. He said he had noticed a considerable improvement in him compared to when he had last seen him in April 2011. He told the psychiatrist he did not mind whether he was in prison or hospital and was fine being in a cell in the main prison. He told him that he was on olanzapine and said he had no issues or concerns. The psychiatrist set a task on the electronic medical record for a mental health administrator to keep him under review via out-patients and to obtain his records from Three Bridges. At interview, he explained that SystmOne is a task based system and clicking an action box should result in a task for the administrator to make an appointment for him.

44. On 6 January, the man's medical record shows that parts one and two of the Three Bridges medical report were received and scanned into his record. On 11 January, another entry records that "The man – discharge summary" was received and scanned in.

45. On 24 January 2012, the immigration authorities wrote to the man telling him that, in the light of his conviction, he was liable to deportation at the end of his sentence.

46. On 4 March 2012, the man's personal officer wrote on his electronic prison record "This individual's behaviour is very strange. He remains quiet however".

47. A multi-agency risk assessment panel (MARAP) meeting took place on 7 March 2012 between the man's offender manager, his offender supervisor, two officers from British Transport Police and the prison's seconded probation officer. The meeting noted he had not received any visits since 13 March 2011. He was reported to be in telephone contact with his social worker and his cousin. He was in a single cell on Houseblock 1. He was described as having calmed down since taking olanzapine and had not shown any aggression to staff or prisoners. He kept himself to himself but was not thought to have been targeted or bullied by other prisoners. The offender supervisor reported that he told him in December 2011 that he was not suicidal. His previous ACCT and the contents of a letter found on him when he was arrested in October 2010 (which detailed people he thought wanted to kill him) were noted.

48. A sentence planning meeting took place on 20 March 2012. After the meeting, the offender supervisor wrote on the man's NOMIS record that he had been identified as a potential risk to staff and prisoners if he formed a dependent relationship with someone or stopped taking his medication. He asked staff to report any change in the man's behaviour or if he stopped taking his medication. He said he submitted a security information report (SIR) and referred him to the psychology department.

49. During March 2012, the man successfully applied to be a foreign national orderly. The foreign national co-ordinator told the investigator that the man was a regular at the foreign national prisoner forum meetings. She said he did not interact with anyone but used to stand and stare at her and would only speak when spoken to. Part of the foreign national orderly's role is to talk to other prisoners and ask them if they have any questions. She remembered asking him to ask a list of people if they needed to see the Detention Advice Service, a task that he found very difficult.

50. The foreign national co-ordinator said she wanted to give the man a chance in the role because she thought he seemed vulnerable and isolated. She said officers on his houseblock (he lived on Houseblock 1 at the time) told her they were concerned that he stayed in his cell and did not mix with the other prisoners as foreign national orderlies were expected to do. Eventually she decided to terminate his probationary period as an orderly because he was not suited to the job. On 17 May she made an entry in his records that she would contact his personal officer to see whether he could benefit from education classes or another purposeful activity. He subsequently started an art class.

51. On 16 August 2012, an officer wrote on his record that she had spoken to the man on several occasions as his personal officer. She said he kept himself to himself and did not have any current issues.

52. The man saw the prison psychiatrist for a mental health review on 10 September 2012. He told him he was due to transfer to another prison but was not sure which one. He said he had no problems, was coping well on the wing and was studying art in education. He said his mood was slightly low but he had no thought of harming himself. He hoped to remain in the UK and was appealing his deportation to Sri Lanka. The psychiatrist said he felt his mental state had improved considerably since his return to Belmarsh and he appeared very stable. He said he had felt better since being on olanzapine and wanted to stay on it. He agreed a small reduction in dose to 15mgs daily with a review in two months.

53. On 10 October 2012, an officer wrote in the man's record that he had no current concerns.

54. On 25 October 2012, the man's offender manager visited him and completed an OASys assessment (an assessment of the person's risk to themselves and others in and out of prison). She concluded that he presented a medium risk to staff and prisoners. She had concerns about his vulnerability and ability to cope in custody but did not identify any current risk of suicide or self-harm. She said that he appeared to be coping well in prison but should be monitored because he might be vulnerable to bullying. He had decided to live as a man but if he decided to pursue gender reassignment again, she felt that this might make him vulnerable in prison. She concluded that he was at greatest risk to others when he was not taking his medication.

55. The prison psychiatrist reviewed the man on 19 November. He said his mental state remained stable despite the reduction of his olanzapine. The psychiatrist found no evidence of psychosis or other symptoms of mental illness. He decided to review him again in two months.

56. On 9 December 2012, an officer wrote in his record that the man continued to keep himself to himself and had no current problems.

57. The prison psychiatrist saw the man on 22 January 2013. He said he was doing well and was keen to reduce his medication further. He said he felt fine. He expected to be deported at the end of his sentence. He was attending education. The psychiatrist agreed to reduce his dose of olanzapine to 10mgs daily. It is not clear why but he continued to receive 15mgs of olanzapine until the error was discovered on 20 March during a medication review by a doctor and this was then reduced to 10mgs as the psychiatrist had agreed in January.

58. The prison psychiatrist next saw the man on 25 March. He noted that he had continued to receive 15mgs of olanzapine after he had agreed to reduce it to 10mgs. The man said he wanted the dose further reduced to 5mgs a day, despite having received the previously reduced dose of 10mgs only since 21 March. The psychiatrist tried to persuade him against this but he was insistent. He said he felt well and did not have any problems. He said he wanted to be drug free and not dependent on medication. The psychiatrist said he could not find any evidence of psychotic symptoms so he reduced the

dose to 5mgs and noted on his medical record that this was due to patient preference.

59. An officer was appointed to be the man's personal officer for the two or three weeks he lived on spur two Houseblock 4. It is not clear exactly when he moved and it appears that he had also lived on Houseblock 2 before that. The officer told the investigator that he was very quiet and did not mix with any other prisoners. He said he encouraged the other Sri Lankan prisoners on the spur to talk to him. They told him that they had invited him in to their cells but he was "peculiar" and did not seem to want to talk to them. He said he was aware that he might have transgender and mental health issues but he did not know the details. He said that his presentation had not changed in the weeks he had known him. He went to education every day but otherwise spent the time in his cell.

60. The regular officer on spur two of Houseblock 4 remembered the man as very quiet and "in the background". He had pointed out to him that there were other Sri Lankan prisoners on the landing. He described him as "very meek, almost subservient" and said he never questioned anything. He said that he hardly made eye contact and looked down at the floor. The officer said there was no indication that he was being bullied and had asked the other Sri Lankan prisoners whether he was being ostracised due to his feminine appearance and mannerisms but they said he was not.

61. The Hindu minister said he remembered the man from both his periods in Belmarsh. During his first period there, the minister described him as not wanting to mix with other people and not interested in keeping himself clean. After a few weeks he had told the minister that he wanted to have a sex change and he supported him spiritually. The minister felt that he was opening up to him but then he was transferred to Three Bridges. He said he had attempted to visit him at Three Bridges but had not been allowed in.

62. The Hindu minister said the man was a changed person when he returned from Three Bridges. He interacted with the other prisoners at the weekly Hindu service and asked him questions. The minister said he seemed less anxious because he knew what his sentence was. He felt that whatever treatment he had received at Three Bridges had obviously worked. He said the man was looking forward to returning to Sri Lanka at the end of his sentence. He told the investigator, "He was not suicidal, I can 100% tell you that; he was not suicidal". He appeared happy when he saw him. He did not notice any change in his behaviour during his second period in Belmarsh.

63. A nurse worked regularly on Houseblock 4 giving prisoners their medication. He remembered the man as a very quiet man who hardly spoke to anyone. He always came for his medication without fail. The nurse said that he only really spoke to him to check he was aware that the prison psychiatrist had agreed to reduce his dose of olanzapine. Often he would not reply if the nurse asked him how he was.

64. Prisoner A lived in cell number 10. The cell directly opposite the man's is cell 9, which is used a room for prisoners to talk to Listeners (prisoners trained by the Samaritans to offer confidential support). He was already on Houseblock 4 when the man moved there. He described him as not very friendly. He said he and the other Sri Lankan prisoners on spur 2 had tried to bond with him but he kept himself to himself and only really spoke to the Hindu minister at the weekly service. He said he looked as though he had mental health problems so they did not want to disturb him. He rarely came out of his cell at association times and sometimes missed meals. He did not think other prisoners bullied him – he thought that most people kept away from him because they knew he was not well. He said he had felt sorry for him.

65. Prisoner B shared cell 10 with Prisoner A. He described the man as always quiet. He had tried to talk to him but he did not seem to want to. Sometimes he joined in conversations but would not start them and did not volunteer any information about himself. He always looked at the floor and appeared stooped. He said he had seemed happier at the Hindu service and joined in with group discussions. He never saw him being picked on my other prisoners. He said everyone let him get on with being himself and that he was the same throughout the period he knew him.

66. Prisoner C lived in cell 13 further down the spur on the opposite side to the man. He knew him from the Hindu service and also walked over to the education block with him every day. He said he was quiet but quite friendly if he was spoken to. He did not start conversations but would answer if approached. He did not seem to be distressed and seemed calm but he thought he was not happy and he looked down at the floor when he walked around. He said he did not mix with other prisoners and rarely came out of his cell at association times.

67. Prisoner D lived in the cell next door to the man for about two weeks before he died. He also said that he did not mix with the other prisoners and rarely talked to anyone. He spent most of the time in his cell. Occasionally he would sit on a chair outside his door during association and watch the other prisoners. He described how he used to walk around with his head down looking at the floor. He looked like a man who was upset but he did not talk to him. He said in the week before he died he heard what he thought was him banging the pipes at the back of his cell. He did not ask him to stop but other prisoners had heard it and shouted for him to stop.

68. Prisoner E lived in cell 11, next door to Prisoners A and B. He said that the man did not talk to the other prisoners on the houseblock, even the other Sri Lankan prisoners. He said he was very quiet. Sometimes he watched other prisoners play pool during association periods. He described him as "closed off to people".

Events leading up to the incident

69. The night patrol officer on Houseblock 4 came on duty at 8.00pm, although his shift did not formally start until 8.45pm. He completed two roll counts

during the shift, one at the beginning of his shift and one between 5.00am and 6.00am. He said he is required to look into every cell and check that the prisoner is there. It was his practice to start his count earlier than 5.00am as he said he was often asked to confirm the numbers not long after 5.00am. He said he is not required to get a response from the prisoners at the early morning roll count. He told the investigator that he did not see or hear anything during his shift which drew his attention to the man's cell. He said that at the early morning roll check he was lying on his bed. He did not notice anything odd about him. He went off duty at 6.30am.

70. Prisoner E said that, at about 10.00pm, the officer had come to his cell to tell his cellmate that he was going to court in the morning. After the officer left he said he had heard someone shouting "help me, help me". He thought it was someone in the cell next door playing a joke so he banged on the wall to ask if they were messing about. The men next door told him they were watching TV. He asked them if they could hear anyone shouting for help. He said that when he heard the officer walking along the landing he shouted, "Someone's shouting for help" and the officer shouted back, "I don't hear it". He thought that this was about 10.30 - 10.45pm. He did not hear any other noise during the night. The officer did not recall him calling to him that night.

71. Prisoner A occupied cell number 10, next door to Prisoner D's cell and opposite Prisoner D's. He said between 10.00pm and 11.00pm he heard what he thought was the man banging on his door and his neighbour shouting at him to be quiet. He said this was very unusual for him as he was usually very quiet. Prisoner B, in the same cell, said at about 10.00pm – 10.30pm he heard someone shouting and screaming. He thought it was prisoners on the spur above who were often noisy and he heard an officer say, "keep it down". Prisoner C, in cell number 13 a few doors further away on the same side, said he had heard someone screaming "help, help" sometime after 9.30pm. He then heard a 'key noise' (the sound made by an officer with keys walking past) and an officer speak to someone. He did not hear what was said. He thought it was someone "acting to give the officer a headache". Afterwards he heard crying. He thought the noise came from the direction of the man's cell.

72. At some time before midnight on 7 April, Prisoner D said he had heard banging noises from the man's cell at the back of the cell by the window. He said it sounded like the pipes or the cupboards above the bed being banged. He said he banged on his wall to stop him making a noise. Later in the early hours of 8 April, he said he heard him at the sink end of his cell near the door. He said he knew where he was because there is a grille above the toilet that makes it easier to hear noises from the neighbouring cell. He said it sounded like he was coughing up into his sink. If he was trying to say something he could not make it out. With hindsight he wondered if he had had something around his throat. He said after about 2.00am he heard no more noises from his cell and assumed he had gone to sleep. The next morning he did not hear any of the usual sounds of him getting up, which he thought was strange.

73. Officer 1 came on duty at 8.00am. The regime at Belmarsh had just changed on 1 April. Previously officers on the day shift started at 7.30am. At about

8.10am a Senior Officer (SO) called staff together for the morning briefing. The briefing finished at 8.22am and officers began unlocking prisoners who wanted to go outside to spend some time in the open air during the exercise period. Prisoners indicated this by pressing their bells which put the red light on outside their cell.

74. At 8.41am, three officer began fabric checks on the cells on spur 2 (these are daily security checks of the locks, window bars and the walls of each cell). As Officer 1 passed Officer 2, who was supervising the prisoners getting their medication in the treatment room, Officer 2 asked him to collect Prisoner D from cell 7 spur 2. The prisoner said he asked the officer to check on the prisoner in cell number 8, as he had heard him crying and shouting the night before.

75. Officer 1 said he looked at his watch and remembered the time was 8.51am, though his watch is always a couple of minutes fast. He looked through the observation panel in the man's cell and saw him sitting on his bed with a plastic bag over his head. He said he was about to call for assistance and go into the cell when he noticed his left hand tied to the bed frame. He said the scene looked suspicious as he could not immediately understand how he could have tied his own arms to the bed. He decided that he needed a witness to go into the cell with him. He shouted to the SO, who was standing further down the spur, that there was a code blue emergency and then radioed the control room.

76. Officer 1 and the SO went into the man's cell together. The SO removed the plastic bag from the man's head. The officer said it was obvious that he was dead. Together they managed to remove a rolled up bed sheet from around his neck. The officer used a cut down tool which all officers carry to cut the shoelace tying his left wrist to the bed. The SO tried to lay him flat to begin cardiopulmonary resuscitation but he could not move him. The officer then noticed that his right wrist was also tied to the bed frame with a shoelace. He tried to cut it with his knife but could not.

77. Officer 3 came into the cell and slid under the bed to try to cut the shoelace from the man's right wrist. The SO then left the cell to ask another member of staff to collect special scissors from the control room. Officer 3 was then able to release his right wrist from the bed frame using these. However, because rigor mortis was present his arms remained looped through the bed frame and the officers were unable to move them.

78. A Physical Education Instructor (PEI) was in the prison gym when he heard the code blue. The PEI is trained in emergency life support and is a member of the prison's emergency response team. He is also a first aid instructor and the prison's first aid co-ordinator. He went straight to the cell and arrived as Officer 3 was trying to cut through the lace around his left wrist. As soon as his wrists were free the PEI and the officers tried to move him into a position where they could start cardiopulmonary resuscitation (CPR). The PEI said he had wanted to move him on to the floor but he was very stiff and his arms were locked behind the bed frame. He said he began CPR with him on the

bed in that position. He told the investigator that knew from his condition that it would not be effective but he felt he had a duty to attempt it.

79. A nurse was in the Houseblock 4 treatment room with a Healthcare Assistant when he heard the code blue on his radio. They went immediately to the cell taking the treatment room emergency bag and oxygen with them. The man was lying on the bed with his head on the frame and his hands behind the bed frame with the PEI attempting CPR. The nurse could not find a pulse and said the man was cold and stiff. There was no blood pressure and his airways could not be opened to allow oxygen to be given because his jaw was stiff. A senior nurse arrived and asked the nurse to return to the treatment room to continue his duties while she took over.

80. The senior nurse said the man was cold and stiff with his left arm stuck through the bed frame. She asked for a defibrillator to assess cardiac output. This was brought from the Houseblock 4 office and attached to him. The defibrillator found no heart rhythm so advised no electric shock. She left the cell to radio for a prison GP to attend because she thought that it was too late to do CPR but she did not have the authority to pronounce death. In the meantime, another nurse and the PEI took it in turn to do chest compressions. They completed six sets of compressions. In between each set the defibrillator advised not to shock. During the sets of compressions the PEI removed one of the sides of the bed frame with a screwdriver in order to move the man further down on the bed. At 9.16am, ambulance paramedics arrived at the cell. They did not perform any CPR and pronounced him dead at 9.18am.

81. The control room log shows that the code blue was called at 8.55am and an ambulance was called at 8.58am. The ambulance arrived at the gate at 9.05am and another set of paramedics arrived at 9.11am. At 9.14am the ambulance was escorted to Houseblock 4.

82. The verification of fact of death form completed by the paramedics shows that the man had rigor mortis and post-mortem staining when examined. He was cold and his pupils were fixed and dilated. Their patient report form LA4 shows that the ambulance arrived at Belmarsh at 9.06am and the crew got to him at 9.16am.

83. Prisoner D said a member of the chaplaincy team visited him afterwards. Listeners (prisoners trained by the Samaritans to offer confidential peer support) also came to see him and he was given advice about how to ask for counselling if he wanted to speak to someone. At interview he told the investigator that he would have liked more support. Prisoner B said that a member of the chaplaincy and a governor had visited him that day and the next day to check he was okay. He said that the Hindu minister spoke to all the Sri Lankan prisoners on the wing and offered counselling.

84. There was no hot debrief for staff on the day. Several days later the staff were offered the opportunity to attend a critical incident debrief but they did not want one.

85. The investigator asked for a copy of the cell bell call record for the night leading up to the incident, but was told that it had been discovered, as a result of her request, that the computer system had not been working and was being repaired.

Family liaison

86. Two officers were appointed as family liaison officers. At 1.30pm that day, they went to the man's cousin's house to inform her of his death but no one was in. They left a note with their contact details and she telephoned the prison at about 3.00pm. Because of her limited English she agreed that an officer should call her after 5.00pm when her husband was home. Both of the prison liaison officers visited his family on 15 April to return the man's property. The prison offered financial assistance with his funeral.

Post-mortem examination

87. We have not seen the post-mortem report but the police investigation gives a preliminary cause of death as asphyxiation.

ISSUES

The man's mental healthcare at Belmarsh

88. During his first period at Belmarsh, the man was cared for on the inpatient unit on an open ACCT. The prison psychiatrist concluded that he needed a period in hospital to establish a diagnosis and to inform a potential defence of diminished responsibility. The clinical reviewer concludes that this referral was timely and appropriate. In April 2011, he transferred to Three Bridges Regional Secure Unit under section 48 of the Mental Health Act. At Three Bridges, he was stabilised on olanzapine and his mental state improved significantly. A definitive diagnosis of his mental health was never established although it was thought he was suffering a psychotic episode at the time of his offence.

89. At a Section 117 meeting in November, it was decided that the man would not get any further benefit from hospital treatment and he should return to Belmarsh after he was sentenced. He went back to Belmarsh on 22 December 2011. At the time he was prescribed 20mgs of olanzapine, 50mgs of sertraline and calceous daily. At his reception health screen and appointment with the GP, he said he was on olanzapine and there is no record that he mentioned sertraline or calceous. Documents from Three Bridges containing information about his medication were requested and received on 23 and 30 December and 6 January 2012. The prescription for sertraline and calceous was not noted and he never received these after his return to Belmarsh. Three Bridges did not complete a discharge summary for him as they should have done. Discharge summaries are a vital method of ensuring that there is continuity in care. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners returning from hospital receive their medication in line with the hospital prescription and a formal discharge summary is requested, if not already provided.

90. Section 117 of the Mental Health Act states that aftercare must be provided to patients who have been detained in hospital following transfer from prison under Section 48 of the Act. Typically this means they are allocated a care coordinator, have multi-disciplinary care planning and review meetings and a written care plan. The type of aftercare required will depend on the circumstances of the individual and health services are entitled to consider their resources when assessing needs. Section 117 gives considerable discretion as to the nature of the aftercare that can be provided. In addition to outpatient treatment it can include support from a community psychiatric nurse, counselling or therapy and assistance from social services.

91. The man was discussed at the multi-disciplinary mental health team meeting on 6 January. It was decided that he should be allocated to the prison psychiatrist's patient list and reviewed periodically in the out-patient clinic. Two psychiatrists reviewed him the same afternoon. Due to an administrative failure, he was not reviewed again by the prison psychiatrist until September

2012. It does not appear that he was reviewed by the multi-disciplinary team after 6 January and there was no written care plan.

92. The prison psychiatrist explained that there is no hard and fast rule at Belmarsh for the case management of patients. Sometimes he takes responsibility, sometimes the patient has a member of the mental health in-reach team and sometimes there is joint case management. In the man's case, he said it made sense for him to take responsibility because he was familiar with his case. He said that staffing levels necessitated the balancing of different case loads.

93. We understand the rationale behind the decision for the psychiatrist to take responsibility for reviewing the man at Belmarsh. However, this made him the de facto care coordinator. In the community, a consultant forensic psychiatrist would not take this role. We do not consider therefore that that this arrangement was satisfactory or in accordance with what is expected under the provisions of Section 117. As a consultant forensic psychiatrist, he was not responsible for verifying what medication the man was on at Three Bridges and he was not responsible for making outpatient appointments to see him or reviewing his medical record or checking his day to day progress in between appointments. Had he been allocated a care coordinator at a less senior level, the issue of the non-prescription of sertraline and calceous, the gap in reviews between January and September 2012 and the fact that a discharge summary was not received from Three Bridges might have been identified and acted on.

94. The man had complex mental health needs. He had decided to live as a man at Belmarsh because he was concerned he would be vulnerable if he chose to live as a woman rather than because he had changed his mind about his gender identity. His offence was against a friend and he had very little family contact or outside support. He was an isolated figure on the wing. All of these are legitimate reasons for him to have been seen more frequently by a member of the mental health in-reach team after his discharge from hospital. Effectively he had no mental health support for nine months after he left the secure unit. His psychiatric oversight resumed again in September 2012 so it is difficult to conclude this omission was a contributory cause of his death, but the lack of ongoing frequent support was unsatisfactory.

The Head of Healthcare should ensure that prisoners transferred to hospital under section 48 of the Mental Health Act are allocated a care coordinator responsible for ongoing support and regular reviews of their care plan and medication when they return to prison.

95. From September 2012, the man asked the prison psychiatrist at almost every review for a reduction in the dose of olanzapine. Although he advised against it, the psychiatrist said that he could not compel him to take a certain dose of olanzapine and he had to accede to his wishes in this matter. The psychiatrist from Three Bridges said that he would not have wanted to see his dose of olanzapine reduced, although he acknowledged that patient preference has to be taken into account in a prison setting. Another administrative failure meant

that his dose of olanzapine was reduced rapidly from 15mgs to 10 mgs to 5mgs in only five days between 20 and 25 March 2013. The clinical reviewer is not able to offer a firm opinion on whether the rapid reduction of olanzapine increased his risk of suicide.

96. The clinical reviewer concludes that the man's clinical care at Belmarsh was not equivalent to that he would have received in the community. He makes a number of more detailed recommendations than those in this report which the Head of Healthcare will need to consider.

Identification of risk of suicide

97. The man displayed very different behaviour during his second period at Belmarsh then when he first arrived there. He lived on a standard wing, initially got a job as a foreign national orderly and later went to education each day. He appears to have lived an isolated existence by choice and resisted the attempts from other Sri Lankan prisoners and some staff to draw him into conversation. A psychiatrist described him as a lonely and tortured person who was not happy with his own identity and who could not bear attention. He had decided to live as a man in prison, not because he had changed his mind about his gender identity, but because he did not want the attention living as a woman would bring. A previous psychiatric report described how he experienced emotional intimacy as intrusive and intolerable.

98. The man had many of the risk factors associated with risk of suicide listed in Prison Service Instruction 64/2011 about safer custody. His offence was one of violence against someone close to him, he had mental health problems, he had a family history of suicide, he had previously attempted at suicide in January 2011, he was living as a man when he wanted to be a woman, he was subject to a life sentence and was at risk of deportation to a country he had left as a child due to religious persecution. He was quite clearly a very difficult man to communicate with and it seems doubtful whether it was possible for anyone to really get to know him. However, he had also been back in Belmarsh for some time without being a concern to staff. The Hindu minister, who of the staff appeared to know him best, could not detect any difference in his behaviour in the period leading up to his death. The list of risk indicators, would suggest that he would always have been at heightened risk of suicide but we do not consider that there was anything about his behaviour which would have indicated that he was planning to take his life at the time he did. The manner in which he killed himself suggests a planned and determined attempt but we consider it would have been very difficult for prison staff to foresee or prevent it.

The night leading up to the incident

99. Several prisoners told the investigator that they heard noises including banging and shouting from the direction of the man's cell during the evening of 7 April. Some of them assumed it was him only after they were told of his death. Prisoner D, who lived next door, did not hear any sound from his cell after 2.00am when he heard him coughing near his sink. The night officer did

not remember hearing any disturbance from his cell that night or any prisoners referring to any noise on the wing. Because of an apparent technical failure it has not been possible to check the electronic cell bell records to see whether he rang his bell, but prisoners nearby did not report hearing it. We have been unable to corroborate the accounts that he made a cry for help to staff or prisoners that night and the position in which he was found suggests a planned and determined attempt to kill himself.

The 6.00am roll check

100. Local Security Instruction (LSI) 2.91 covers roll checks during the night at Belmarsh. The copy we were provided with was due for review in November 2011 but was still apparently the current instruction. There are two night patrol roll checks – at 9.00pm at the beginning of the night patrol duty and at 6.00am. Paragraph two lists what is required. Included is the instruction to staff to ensure that, "A response is obtained from the prisoner and/or there are signs of breathing. If there is any doubt whatsoever the prisoner should be woken".

101. When interviewed, staff said that their understanding was that the 6.00am roll check is simply a visual check unless the prisoner is on an open ACCT. If staff were concerned there was something untoward or they could not see the prisoner, then they would try to get a verbal response or some movement from the prisoner. The custodial manager in charge of security at Belmarsh agreed that the instructions in the LSI did not reflect practice at Belmarsh and said that he would amend the LSI.

102. At the time of writing, we have not received confirmation of the amendment. It is not clear what form the amendment will take. The current instruction does not require officers to wake up prisoners routinely or seek a response unless there is no sign of life. This does not seem unreasonable, and we consider that there should be a check on a prisoner's well-being if there is no sign that he is breathing.

103. It seems likely that the man was already dead when the night officer made his 6.00am roll check. At interview he said he remembered seeing him on the bed but did not see anything unusual. From the description of his position on the bed when he was found and the fact that it would have been quite dark in the early hours of an April morning it is possible that it would not have been immediately obvious to someone simply checking that a person was in the cell, that there was any cause to suspect something was wrong. However, this reinforces the need for officers conducting a 6.00am check to be satisfied that a prisoner is actually alive and take some action if there is no sign that the prisoner is breathing. If he had been sitting on his bed it would not have been unreasonable to seek some response from him. We make the following recommendation:

The Governor should ensure that staff check on a prisoner's well-being if there is no sign that they are breathing at a roll check.

Emergency response

104. Officer 1 raised the alarm promptly and radioed the appropriate emergency code. The control room log shows that an ambulance was not called until three minutes after the code blue was received. PSI 03/2013 (Medical Emergency Response Codes) gives instructions to staff about communicating the nature of a medical emergency and ensuring there are no delays in calling ambulances. Paragraph 5.4 requires that:

> "*when the emergency is called over the radio network an ambulance must be called immediately* [the italics mean that the action is mandatory.]."

105. It is clear that the man was already dead so any delay would not have affected the outcome in his case. While a delay of three minutes might not appear significant it could be important in other cases. The PSI gives a clear instruction that an ambulance should be called immediately. We make the following recommendation:

The Governor should ensure that an ambulance is called automatically when an emergency code is called.

106. The clinical reviewer comments in his review:

> "The attempted resuscitation of the man, who was clearly in rigor mortis, was inappropriate and traumatic for the staff. Although the attempted resuscitation was immediate and followed the correct guidelines of the Resuscitation Council, it cannot be seen as good practice."

107. We agree with the clinical reviewer that the attempted resuscitation was unnecessary and distressing for the staff involved. We understand the commendable wish to attempt and continue resuscitation until death has been formally pronounced, but staff should understand that they are not required to carry out CPR in these circumstances. The European Resuscitation Council Guidelines for Resuscitation 2010, state that, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". The presence of rigor mortis is listed as one of the examples when attempts at resuscitation will not be appropriate. In the man's case, the rigor mortis was very clearly evident. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is appropriate.

108. The investigator was told that there was no hot debrief for staff on the day of the man's death. A critical incident debrief was offered about a week later but the staff involved in the incident said they did not want one. We understand that this was because they were upset that the hot debrief had not taken place and they had not been offered support. PSI 64/2011, gives guidance to staff about actions following a death in custody. Chapter 12 makes it a mandatory

action that, “In line with PSI 08/2010 a ‘Hot Debrief’ must be held immediately after all deaths in custody. A senior member of staff must act as the debriefer and a member of the care team must attend. All staff directly involved in the incident, including healthcare staff, should be invited”.

109. It appears that some of the staff involved were spoken to individually and offered the opportunity to go home early. In a previous investigation into the death of a man at Belmarsh in 2011, when some staff were not invited to a hot debrief, we made a recommendation that the Governor should ensure that all staff are invited to a hot debrief in any future death in custody. Although the recommendation was accepted it does not appear to have been implemented in practice. We are also aware that a hot debrief did not take place after a subsequent death in April 2013.

110. The hot debrief is an important part of staff support after any traumatic event and is also an important way for staff to assess whether there are any urgent actions that need to happen to keep other prisoners safe. We are concerned that the situation at Belmarsh has not improved since 2011 and we repeat the recommendation.

The Governor should ensure that all relevant staff are invited to a hot debrief after a death in the prison.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners returning from hospital receive their medication in line with the hospital prescription and a formal discharge summary is requested, if not already provided.

2. The Head of Healthcare should ensure that prisoners transferred to hospital under section 48 of the Mental Health Act are allocated a care coordinator responsible for ongoing support and regular reviews of their care plan and medication when they return to prison.

3. The Governor should ensure that staff check on a prisoner's well-being if there is no sign that they are breathing at a roll check.

4. The Governor should ensure that an ambulance is called automatically when an emergency code is dialled.

5. The Governor and Head of Healthcare should ensure staff are given guidance about the circumstances in which resuscitation is appropriate.

6. The Governor should ensure that all relevant staff are invited to a hot debrief after a death in the prison.

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that prisoners returning from hospital receive their medication in line with the hospital prescription and a formal discharge summary is requested, if not already provided.	Accepted	The Head of Healthcare will ensure that any prisoner who is returning from hospital will be accompanied by a formal written discharge summary. This will then be scanned onto system one.	Completed	
2	The Head of Healthcare should ensure that prisoners transferred to hospital under section 48 of the Mental Health Act are allocated a care coordinator responsible for ongoing support and regular reviews of their care plan and medication when they return to prison.	Accepted	If there is a diagnosis of severe and enduring mental illness the patient will be allocated a Care Coordinator. The appropriate Care Coordinator will be selected from the Mental Health Team, including the in reach Team, Psychiatrists and Psychologists, as reflected in the community.	Completed	

3	The Governor should ensure that staff check on a prisoner's well-being if there is no sign that they are breathing at a roll check.	Accepted	Staff will be reminded by NTS of the instructions given under the LSS and the Safer Custody guidelines on what checks for prisoner's well – being need to be carried out when conducting a roll check	29/11/2013	
4	The Governor should ensure that an ambulance is called automatically when an emergency code is dialled.	Accepted	In the event of a serious medical emergency an ambulance will be called automatically and if it is then assessed as not being required by medical staff it will be cancelled at the earliest opportunity.	11/11/2013	
5	The Governor and Head of Healthcare should ensure staff are given guidance about the circumstances in which resuscitation is appropriate.	Accepted	The Head of Healthcare and the Governor will draft clear guidelines for staff about the circumstances in which resuscitation is not appropriate. This will be reiterated to staff via notice to staff and emphasised through Safer Custody Meetings.	31st Jan 2013	
6	The Governor should ensure that all relevant staff are invited to a hot debrief after a death in the prison.	Accepted	A notice to all Governor grades and managers will be circulated to ensure that in the cases of serious incidents a "hot debrief" must be carried out and who else should be invited to attend at the time.	04/11/2013	