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 Parc in May 2014

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 hanged in his cell at HMP Parc on 28 May 2014. He was 28 years old. I offer my condolences to the man's family and friends.

An investigator was appointed and Health Inspectorate Wales (HIW) reviewed the clinical care that the man received at Parc. Staff at Parc cooperated fully with this investigation.

The man was sentenced to four years and six months imprisonment on 7 June 2013, for a violent offence, and another nine months on 7 August 2013, for affray against a former partner. It was his first time in prison, but he settled into the regime well. The man lived in a unit at Parc that specialises in family interventions.

On 16 May 2014, the man told staff and prisoners that he had relationship problems with his current partner. Officers noticed that he was less happy than normal and spoke to him about his problems. The man was open about his relationship difficulties but said that he did not have any thoughts of suicide or self-harm and officers decided that he did not need to be managed under suicide and self-harm prevention procedures. On the morning of 28 May, officers found the man hanged in his cell.

The investigation found that there was one occasion when the man returned to the prison after a court appearance and was not assessed as he should have been. However, this was sometime before his death. Prison staff were fully aware that the man was upset about his relationship in the days before his death and supported him appropriately. I am satisfied that there was little indication that the man intended to kill himself and I do not consider that staff at Parc could reasonably have been expected to anticipate or prevent 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 2015**

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SUMMARY

1. The man arrived at HMP Cardiff on 7 June 2013, after he was sentenced to four years and six months imprisonment for a violent offence. He moved to HMP Parc on 17 June. On 7 August, he received a further conviction for affray (including an assault against a former partner) for which he was sentenced to nine months in prison.

2. This was the man's first time in prison. He settled well and was a trusted prisoner. The man was in good health and had little contact with healthcare services while he was at Parc. No one considered that he was at risk of suicide or self-harm.

3. About a month before his death, prison staff noted that the man appeared to be in a low mood and different from his usual self. He told staff and prisoners that he had relationship problems with his partner. The man often shared his concerns with others and, although he was upset, he said that he was not considering suicide or self-harm. Officers thought that he had several protective factors, including his relationship with his children, and did not believe that formal suicide and self-harm prevention procedures were necessary. On Tuesday 27 May, the man tried to call his partner many times from the telephone is his cell and spoke to her several times. The prison was not aware of these calls at the time, but the transcripts make it clear that the man was very anxious about the state of their relationship.

4. At 6.55am on 28 May, officers conducting a roll check found the man hanged in his cell. An officer radioed a code red emergency over the radio (it should have been a code blue) and, together with another officer, immediately entered the man's cell. It was clear that the man had been dead for some time as rigor mortis was present, but nurses attempted to resuscitate him. Paramedics arrived and pronounced the man dead at 7.14am.

5. We consider that it would have been difficult for staff to have predicted the man's actions and prevented his death. Staff and other prisoners gave him a lot of help and support and considered he had a lot to live for, which made suicide unlikely. The investigation identified some issues, which the prison will need to address, but would not have affected the outcome for the man. As we have found before at Parc, staff used the wrong emergency code when summoning help. As we have recently made a recommendation to the prison about this we do not repeat it here. We also found that on one occasion, when the man returned from a court appearance, staff did not assess his risk of suicide and self-harm as they are expected to do. We are also concerned that nurses felt obliged to attempt to resuscitate the man when it was evident that he had died. We make two recommendations about these matters.

THE INVESTIGATION PROCESS

6. We issued notices to staff and prisoners at Parc informing them of the investigation and inviting them to contact the investigator if they had any relevant information. No one responded.

7. The investigator visited Parc on 4 and 5 June 2014, and obtained the man's prison and medical records. She met the Director and the security manager, and interviewed staff and four prisoners. The investigator informed the Director of her initial findings. The investigator interviewed the man's legal representatives.

8. Healthcare Inspectorate Wales reviewed the man's clinical care at the prison.

9. The investigator informed HM Coroner for Cardiff about the investigation. We have sent him a copy of this report.

10. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation and allow them to identify any relevant matters which they wished the investigation to consider. The man's family wanted to know whether the man was being monitored as at risk of suicide and self-harm at the time of his death and whether he should have had the items he used to harm himself. His parents wanted to know whether there was CCTV coverage of the man's partner's visit on Monday 26 May. They believed this would have shown he was distressed and should have prompted officers to offer more support. We regret that we did not request the CCTV footage until 12 August, by which time the CCTV footage had been taped over automatically, which happens after 60 days.

11. The man's family received a copy of the draft report and indicated that they were satisfied with the findings.

HMP PARC

12. HMP Parc is run by G4S Care and Justice Services on behalf of the Prison Service. It holds more than 1,400 convicted men and young adults on remand or convicted and has a unit for around 60 young people under 18. It has a specialist family interventions unit, where the man lived, where prisoners are helped to develop and maintain positive and healthy relationships with their partners and children.

Her Majesty's Inspectorate of Prisons

13. The most recent inspection of HMP Parc was in July 2013. Inspectors found that Parc delivered good or reasonably good outcomes in every area inspected. Most prisoners reported feeling safe and care for prisoners at risk of suicide and self-harm was found to have improved since the previous inspection. Eighty per cent of prisoners said that staff treated them with respect and Inspectors observed good interactions and a culture of mutual respect. Inspectors were impressed by the prison's work to support family relationships and noted the prison's innovative approach and range of initiatives as good practice.

Independent Monitoring Board

14. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its most recent annual report, for the period ending February 2014, the IMB noted that several courses are organised to prepare prisoners for release specifically with regards to reducing their risk of re-offending, and that the personal officer scheme had been improved by the introduction of a contact log.

Assessment Care in Custody and Teamwork (ACCT)

15. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. Once a prisoner has been identified as at risk, the purpose of the ACCT process is to try to determine the level of risk, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Recent deaths at Parc

16. Since 2008, there have been three self-inflicted deaths at Parc. In the investigation report into a death in April 2014, we made a recommendation about emergency code calls. The prison had not received the report at the time of the man's death.

KEY EVENTS

17. The man was sentenced to four years and six months imprisonment on 7 June 2013, for violent offences. He was sent to HMP Cardiff. There was a restraining order in force preventing the man from contacting his former partner and their children. This was the man's first time in prison.

18. While the man was at court on 7 June 2013, his legal representative, had told escort staff that she was concerned about the man because he was tearful and worried about the length of his sentence. The legal representative told the investigator that she did not think that the man would harm himself but she wanted the escort staff to know that he was upset. The escort staff completed a suicide and self-harm warning form. When he arrived at Cardiff, reception officers did not open an ACCT as the man told them he had no thoughts of suicide or self-harm. (We have made a number of recommendations to Cardiff about the operation of suicide and self-harm prevention procedures and the identification of risk factors in the reception area.)

19. On 17 June, the man moved to HMP Parc. A mental health nurse, carried out an initial health screen and noted that the man did not raise any issues about his physical or mental health. She recorded that he was fit and well and had no thoughts of suicide or self-harm. The mental health nurse had no concerns about him.

20. Each prisoner at Parc is assigned a personal officer, to be their first point of contact for any problems. Personal officers are expected to get to know the prisoners they are responsible for and record notes on the prisoner's personal record once a month, after speaking to them. The man's first personal officer, recorded that the man had settled in prison well and was an excellent worker and a trusted prisoner. He worked in the visits hall and tea bar and often worked extra shifts because he liked to use his time purposefully.

21. On 30 June, the man moved to T4 unit, the family Interventions unit, as he wanted to work on his relationship with his partner and children. The unit offers prisoners the chance to take part in a range of programmes and activities to help develop and support their family relationships. Prisoners are allowed extra family visits in an area designed for families and with normal domestic furniture. All prisoners on the unit have to be assessed as enhanced prisoners under the Incentives, Earnings and Privileges (IEP) programme. There is a close relationship between staff and prisoners on the unit as the staff get to know the prisoners' families, their domestic circumstances and participate in interventions with the prisoners and their families. The same staff group work in the visits hall with the prisoners.

22. On 4 July, the man told a mental health nurse, at a routine mental health review, that he was coping well in prison and had no mental health problems. He said he had no thoughts about harming himself. The mental health nurse and the man agreed that there was no need for any follow-up appointment. Later, the man did not attend several appointments for vaccinations. He had no other contact with healthcare staff before his death.

23. On 7 August 2013, the man was convicted of a further offence of affray and was sentenced to a further nine months in prison. The victim was a former partner and two other charges against his former partner were left to lie on the file. His release date was 21 January 2016. At court, his legal representative was concerned that the man appeared very anxious about his sentence and he told the escort staff. The escort staff completed a suicide and self-harm warning form to alert the prison to this. The legal representative told the investigator that he did not think that the man would harm himself, but he wanted staff to be aware that he was upset about getting a consecutive custodial sentence. As well as the warning form, this information was included in the man's escort record. There is no evidence that reception staff considered this when he returned to Parc or that anyone from the healthcare team assessed the man's risk of suicide and self-harm when he returned to Parc from court.

24. Over the next months, the man completed a number of offending behaviour courses in line with his sentence plan. Staff we spoke to, described the man as a happy, reliable and helpful member of the unit. Another officer became the man's personal officer in February 2014, but said that she had worked closely with him before that time, because of the nature of the unit. She made regular entries in his personal record, noting that he was a hard worker and a valued member of the unit. She told the investigator that the man had not mentioned any concerns or worries which indicated that he was not coping or that he was at risk of suicide or self-harm.

25. On 16 May 2014, the man told an officer that he was feeling low because he was having problems with his current partner. The officer told the wing managers who then spoke to the man. The man told them that he did not have any thoughts of suicide or self-harm and after speaking to him, the wing managers were satisfied that they did not need to open an ACCT. The officer recorded the decision in the man's personal record.

26. The officer told the investigator that he had not opened an ACCT because the man had said he had no intention of suicide or of harming himself. He also considered that the man had several protective factors, which would make it unlikely that he would harm himself. These included his relationship with his children, that he had settled into the prison regime, was successfully completing interventions and had the prospect of moving to an open prison. He said that he was also aware that the man often spoke to officers and other prisoners about his problems. He was able to open up to them and they gave him good support.

27. On 23 May 2014, the man's personal officer noted that the man seemed low in mood. He told her that his partner had not turned up for some recent visits. (His prison records show that the man's partner and children were due to visit on 23 March, 16 April, and 26 April but they did not attend.) The personal officer encouraged the man to talk to his partner about this, and other staff if he needed support. The man said that he would.

28. The personal officer told the investigator that she knew the man very well and had been his personal officer for six months when he died. She said that in the month before he died, the man had he told her and other staff that he was having problems in his relationship with his current partner and this was upsetting him. Two officers also told the investigator that he had talked to them about this. None of the officers considered that the man was at risk of suicide or self-harm because of the difficulties in his relationship.

29. On Monday 26 May, the man's partner and children came to the prison for a family visit, as part of the man's "Building Better Relationships" programme. This was in addition to his normal prison visit allowance. The visit took place in the family lounge room and was recorded on closed circuit television (CCTV). Unfortunately, the CCTV footage had been deleted by the time we asked to see it.

30. The manager told the investigator that the man and his partner argued at the start of the visit. However, they then seemed to settle and became close and amorous. The manager said that he had warned the man about getting too physically close. After the visit, the manager said that the man told him that it was one of the best visits he had ever had. He said he appeared happy and had "a spring in his step" when he went back to his cell afterwards. This account was corroborated by the man in a telephone conversation with his partner's friend on 27 May at 7.17pm. The man said "[his partner] came in yesterday and we were all over each other like a rash. We were back together, [she] told me we were back together." The manager was present throughout the visit and said that the man did not appear distressed.

31. The personal officer said that she worked with the man in the visits hall on 27 May, when he had seemed his usual happy self. However, on the evening of 27 May, the man had told her that he could not get through to his partner on the telephone. The personal officer said that the man seemed anxious and a little angry. He did not tell her what was said in the calls, but said that he would call his partner again that night and would wait for her visit, which was planned for the next day, 28 May.

32. The man had a telephone in his cell and his cell telephone records show that on 27 May, he used the phone over 100 times. These were mostly unanswered calls to his partner. When he spoke to his partner, they talked about their relationship difficulties. The man said that he thought she was seeing someone else and much of the conversation was about whether they were still together or not.

33. As the personal officer was off duty the next day, she asked another officer to keep an eye on the man. However, she told the investigator that although the man had appeared upset, there was nothing in his manner which suggested to her that he had any intention of harming himself and she did not consider opening an ACCT. The man had said that he was looking forward to seeing his children the next day and sorting things out with his partner. The officer told the investigator that he looked in on the man that evening to check that

he was all right and he seemed settled. The officer finished his shift at 8.00pm.

34. At 8.56pm, the man phoned his father and asked him to collect his tools from his partner's shed as they had split up. At 9.56pm, the man called his father again and asked him if he had spoken to his partner. His father had not done so, and advised the man to let things go. The man made two further calls. The first was to a friend, when he left a message asking the friend to ask his partner to turn her telephone on and answer his calls. The next was to his partner at 10.58pm. He left the following message: "Guess you don't want to speak to me, I love you with all my heart babe, don't ever forget that will you?"

35. On 28 May, the man's first personal officer and another officer came on duty around 6.45am. The officer told the investigator that, when he got to T4 wing, the man's first personal officer was doing the roll check to establish that all prisoners were present in their cells. The officer went to the unit office.

36. The man's first personal officer estimated that he arrived at the man's cell (cell 22) at about 6.50am. He opened the observation flap and, as it was dark, put the night light on. He could not see the man in bed, as he would have expected. He them saw him crouched against the left wall of the cell. He described him as bending, as if to sit on a chair. The man's first personal officer could not get a response from the man so he called the officer and radioed a code red emergency at 6.52am and opened the cell. (A code red is an emergency code used if a prisoner is bleeding profusely. As a result, staff should call an ambulance immediately and bring appropriate emergency equipment. Parc had previously had used code red for all medical emergencies, but changed to code blue in line with a national instruction issued in 2013.) The officer said that it took him just seconds to get to the man's cell and he and the man's first personal officer entered the cell. The control room called an ambulance at 6.53am as soon as they received the code red emergency call. The ambulance arrived at 7.04am.

37. The officers found that the man was suspended by a ligature, made of a shoe lace wrapped in a towel, tied around his neck and attached to a picture board, which was fixed to the wall. The officer supported the man's body while the man's first personal officer cut the ligature.

38. The man's first personal officer, who was first aid trained, told the investigator that the man's body was rigid and his eyes fixed, and he could not find a pulse. He said that he thought that the man had been dead for some time as rigor mortis had set in. The officers laid the man on the cell floor and two nurses arrived. One of the nurses noted in the clinical records that the man's skin was waxy and cold and there were no signs of life. She said that rigor mortis was noticeable (his face, arms and hands and legs were stiff) and she could not find a pulse. While she was assessing the man, the man's first personal officer brought a bag with emergency equipment, including a defibrillator (a life-saving device that re-starts the heart by giving an electric shock in some cases of cardiac arrest). The nurse arrived shortly afterwards.

39. The nurse noted that she was unable to open the man's mouth and could not give him oxygen, and as mucous was coming from the man's nose she was unable to give rescue breaths. She therefore started chest compressions. The nurse attached the defibrillator to the man, but it did not detect a heart rhythm to shock. The nurse told the investigator that she did not feel comfortable continuing chest compressions on a man who was clearly dead. However, the lead nurse had arrived and instructed the nurses to continue emergency treatment until paramedics or a doctor pronounced the man dead. The two nurses continued carrying out chest compressions until paramedics arrived and pronounced the man dead at 7.14am.

40. Staff informed prisoners on the unit about the man's death and offered them support. The Director debriefed the staff who were involved in the emergency response and ensured they were able to access support if they needed it. The staff said that the debrief was helpful.

Family liaison

41. The man had nominated his partner as his next of kin, but prison staff knew that the man had lived with his parents immediately before he was sentenced. The Director and a prison chaplain, the prison's family liaison officer, decided to notify the man's partner and then go to the man's parents' home to inform them.

42. The Director and FLO arrived at the man's partner's home at 9.45am and informed her of his death. The man's partner immediately telephoned his parents and let them know. The man's partner said that he had recently threatened to harm himself, and that he had recently cut his arms. She said that he had told her that officers were aware of this and had checked his arms every morning, but were reluctant to open an ACCT in case it stopped him progressing to an open prison. The manager told the investigator that he was not aware of the man ever harming himself and officers did not check his arms. He said that the man generally wore a T-shirt and his arms were visible.

43. The Director and FLO then visited the man's parents. The FLO continued to liaise with the man's partner and his parents and the prison contributed to the cost of the man's funeral, in line with national Prison Service guidance. On the afternoon of 28 May, the FLO held a memorial service on T4 unit for the man, which staff and prisoners attended. Prisoners raised money for the man's family.

Information from other prisoners

44. When the investigator visited the prison on 4 June, she interviewed four prisoners who lived on the family interventions unit. The prisoners knew the man well and said he had talked to them about his personal problems. One prisoner said that the man had told him that his partner was seeing someone else and that he thought she was trying to push him [the man] away. He said staff on the unit had helped the man a lot. The prisoner believed that ACCT monitoring would have put more pressure on the man and he would have been more likely to harm himself. He had not thought that the man would harm himself and was very shocked and upset when he heard what had happened. His opinion was that the staff had been brilliant in supporting the man. Two other prisoners who lived next door to the man, both agreed that staff could not have helped the man more. However, another prisoner said that he thought that staff could have checked on the man more often during the night of 27/28 May.

Post-mortem examination

45. A consultant pathologist, conducted a post-mortem examination on 29 May. He found that the man had died from asphyxia due to the ligature around his neck. There was nothing to indicate he was under the influence of alcohol or drugs at the time. The pathologist noted that there were no other obvious external injuries.

ISSUES

Clinical care

46. Healthcare staff assessed the man when he arrived at both Cardiff and Parc. He also had a routine mental health review at Parc. None of the healthcare staff who saw the man considered him to be a risk to himself or others. He had no health problems while he was in prison. Healthcare Inspectorate Wales found that that the level of care the man received was appropriate and timely and comparable to that which he would have received in the community.

Assessment of risk of suicide and self-harm

47. When the man was initially sentenced, on 7 June 2013, his legal representative was concerned about him (although she did not consider he would harm himself). Court custody staff noted these concerns on the man's escort record and completed a suicide and self-harm warning form. A reception nurse at Cardiff noted that the man did not express any suicidal or self-harm ideas. The first night officer at Cardiff completed a first night assessment and noted that the man had no concerns. No one considered that the man was at risk of suicide and self-harm at Cardiff so staff did not open an ACCT. There is nothing to indicate that the man was at increased risk after that during his short time at Cardiff. We are satisfied that when the man arrived at Parc on 17 June, there was no reason to consider that he was at increased risk of suicide and self-harm.

48. On 7 August 2013, the man attended court from Parc and was sentenced to a further nine months imprisonment. His legal representative, was concerned about the man's reaction to the sentence although he did not consider he was at risk of suicide or self-harm. He alerted court escort staff to his concerns, who in turn noted this on his escort record and completed a suicide and self-harm warning form.

49. Safer custody staff at Parc told the investigator that admissions staff screen all prisoners when they return from court if there is a change in their circumstances. They are asked if they want to see the nurse and if support is needed it would be arranged in the form of ACCT or referrals to mental health services. However, there is no evidence that the man received any further screening when he returned to the prison after attending court on 7 August or what weight staff attached to the suicide and self-harm warning form.

50. Guidance in Prison Service Order (PSO) 3050 (Continuity of healthcare for prisoners) states:

> "Events that require a prisoner to leave the prison and pass back through prison reception [as the man did], can have significant impact on the health of a prisoner."

51. The PSO lists events such as a court appearance or sentencing as factors that can impact significantly on the health of a prisoner and instructs prisons to have protocols in place for screening such prisoners for any potential healthcare, or suicide/self- harm issues. We do not consider it is satisfactory simply to ask prisoners whether they want to see a nurse as appears to be the process at Parc. We make the following recommendation:

The Director and Head of Healthcare should ensure that all prisoners have a health screen after court appearances to assess any potential health or suicide and self-harm issues and that this is recorded.

52. After this court appearance on 7 August 2013, there is no further evidence that that there was anything about the man's circumstances to suggest he should be considered as at risk of suicide and self-harm at Parc, until May 2014.

53. On 16 May 2014, staff noticed that the man appeared to be in a low mood, and wing managers spoke to him. He said he was having problems in his relationship, but did not have any thoughts of suicide or self-harm. Two managers and other members of staff subsequently assessed that the man did not need to be managed under ACCT procedures. They considered that the man had several positive protective factors and was open about his problems and talked about them with friends and staff on the wing. It seems clear that staff were very aware of the man's change in mood and made time to talk to him. He also had support from other prisoners.

54. Three prisoners who knew the man well, told the investigator that staff had done everything they could to help the man. Although another prisoner said that he thought that staff should have checked the man more frequently on the night of his death, this was in hindsight and he could not give any evidence why he thought this.

55. Staff judgement is fundamental to the ACCT system. ACCT relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. They must balance this against the prisoner's known risk factors and their presentation. Prison Service Instruction (PSI) 64/2011 states that "all staff who have contact with prisoners must be aware of the triggers that may increase the risk of suicide, self-harm or violence and take appropriate action". There are a number of identified risk factors listed in the instruction, including issues such as previous deliberate self-harm, mental illness, early days in custody and relationship problems.

56. The man had been settled on T4 for approximately 11 months and staff and prisoners knew him well. He was not mentally unwell, had never told wing or healthcare staff that he was likely to harm himself during his time at Parc and had never done so. He told healthcare staff that he had previously harmed himself, but this was 14 years earlier, when he was being bullied at school, and was not relevant to his current situation. He had also previously been diagnosed with depression but, when he arrived at prison, said that he was not depressed. There was no evidence that the man was bullied on T4 wing

and he had good relationships with staff and prisoners. He told staff that he did not have any thoughts of suicide or self-harm.

57. We have also considered whether officers on the wing gave the man sufficient support during his relationship difficulties. The personal officer and another officer all told us that they were aware of his problems, but that they spoke to him about them and were satisfied that he was not at risk of suicide and self-harm at that time. The man's first personal officer told us that he was also aware, although he had not spoken to the man himself. The personal officer asked the other officer to keep an eye on the man on the evening of 27 May, and the officer said that he spoke to him and the man had said that he was all right. However, after the officer left, the man made further telephone calls from his cell in which he sounded distressed. Staff were not aware of these calls. Although the number of calls the man tried to make that day suggested a level of anxiety, the telephone system is automatic and as the phone was in the man's cell, staff would not have known how often he had tried to make calls.

58. Prisoners on T4 unit are there specifically to work on their family relationships. The man had been convicted of a violent offence against a previous partner, and staff were aware of this. Officers and other prisoners knew that the man was having relationship problems although, as recently as two days before the man's death, he had what he described as his best visit ever with his partner. His demeanour only changed late on 27 May, and the personal officer asked the officer to keep an eye on him. The man also said that he would talk to his partner at a visit the next day.

59. It is difficult to see how officers could have foreseen that the man would take his own life that evening, and we consider that officers, who knew him well, supported him appropriately. Even if they had begun ACCT procedures, it is unlikely that the man would have been regarded as high risk and subject to frequent monitoring. In the circumstances, we are satisfied that staff made a reasonable decision not to open an ACCT.

Emergency response

60. Prison Service Instruction (PSI) 3/2013 Medical Emergency Response Codes, issued in February 2013, sets out the actions staff should take in a medical emergency. It contains mandatory instructions for prisons to efficiently communicate the nature of a medical emergency using a two level code system to differentiate between a blood injury and all other injuries. It recommends that code red be used for blood or burns and code blue for breathing and collapses. This is to ensure that staff take relevant equipment to the incident and that there are no delays in calling an ambulance. The PSI states that all prison staff should be made aware of and understand the instruction and their responsibilities during medical emergencies. Parc has an appropriate instruction to staff in place.

61. When the man's first personal officer found the man unresponsive in his cell on 28 May, he called an emergency code red over the radio. According to the local instruction he should have called a code blue emergency.

62. As the man had been dead for some time, the fact that the man's first personal officer used emergency code would not have made a difference to the outcome. The confusion in the use of codes appears to be because Parc previously used a single code red system for all medical emergencies. It is evident that the new system has not yet bedded in and it is important that codes are used correctly. In this case there was no delay, staff brought the correct emergency equipment and called an ambulance immediately. As we have made a recommendation about this matter to Parc in another recent report, which Parc received after the man's death, we do not repeat it here.

63. It is evident that the man had been dead for some time when healthcare staff arrived at his cell. The nurse said that she tried to open the man's mouth to fit an airway but she found it difficult because of the rigidity of the man's mouth. She described the man as being in rigor mortis, and said that both she and other colleagues thought that he was clearly dead. However, a senior nurse told them to continue with resuscitation until paramedics or a doctor arrived. The nurses continued the resuscitation attempt with difficulty.

64. Healthcare Inspectorate Wales commented that the only staff who can certify death in a prison are doctors and paramedics. However, that does not mean that resuscitation should always be attempted or continued until death is formally recognised. 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 guidelines define examples of futility as rigor mortis and the presence of post-mortem staining. We consider that the nurses should not have been required to continue to attempt to resuscitate the man. Staff need guidance and reassurance about when it is acceptable not to perform CPR, to minimise the distress for all involved. We make the following recommendation:

The Director and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is not appropriate

RECOMMENDATIONS

1. The Director and Head of Healthcare should ensure that all prisoners have a health screen after court appearances to assess any potential health or suicide and self-harm issues and that this is recorded.

2. The Director and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is not appropriate.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Director and Head of Healthcare should ensure that all prisoners have a health screen after court appearances to assess any potential health or suicide and self-harm issues and that this is recorded.	Accepted	The Head of Healthcare will put in place a procedure to ensure that a member of healthcare staff sees each prisoner on return from Court. A further assessment will be conducted of prisoners about whom concerns have been raised or information that there may be an issue has been received. When a clear risk of self-harm has been identified an ACCT will be opened. All actions and the results of any further assessments conducted will be recorded on SystmOne.	Head of Healthcare February 2015	
2	The Director and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is not appropriate.	Accepted	In October 2014, the British Medical Association, RCN and Resuscitation Council issued new guidance on making decisions about attempting cardiopulmonary resuscitation (CPR). NOMS Equality, Rights and Decency Group is due to meet with NHS England in early 2015 to discuss this document, after which revised guidance will be issued to staff in prisons.	NOMS Equality, Rights and Decency Group and NHS England March 2015	