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 in September 2014 at HMP Whitemoor

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 Whitemoor in September 2014. He was 46 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at the prison was undertaken. Whitemoor cooperated fully with the investigation.

The man was arrested for murder in August 2009. He was convicted and sentenced to life imprisonment in 2010. In July 2012, there was television coverage about his offence, the circumstances of which had attracted a lot of media interest. Officers were concerned about the implications for his safety and supported him until the threat of possible retaliation from other prisoners had subsided.

On 26 August 2014, the man told staff about a new television documentary, scheduled for broadcast on 3 September. He discussed this with his personal officer and they agreed to review the situation after the programme had been shown. Over the next few days, officers and prisoners we spoke to said there was nothing to suggest that he was distressed. On 1 September, an officer found him unresponsive with a cord around his neck attached to the bed frame. Attempts to resuscitate him were unsuccessful. He left two notes in which he made it clear that he had intended to kill himself.

The investigation did not find any evidence that the man was under threat because of the forthcoming television programme, and I am satisfied that staff at the prison took appropriate steps to safeguard him. I do not believe that staff could reasonably have foreseen or prevented his actions in September.

Although it would not have affected the outcome for the man, I am concerned that the emergency response was too slow. This is something I have raised with the prison before and it is important that the weaknesses we identify are addressed as such delays could be crucial in a future emergency.

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 involve din my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2015**

CONTENTS

SUMMARY

1. In August 2009, the man and his co-defendant, a 15 year old girl, were arrested for the murder of two people, one of whom was the girl's father. The case attracted a lot of publicity. He was sentenced to life imprisonment on 4 August 2010 and was transferred to HMP Whitemoor on 22 November.

2. In July 2012, the man told staff about television coverage of his offences. He was worried about how other prisoners might react and staff supported him until they thought the risk of any retaliation had subsided.

3. On 26 August 2014, the man told an officer that a documentary about his case was to be shown. He was concerned that other prisoners might think that he had been in a relationship with his co-defendant, who was a child at the time, and that this might place him in danger on the wing. His personal officer offered to move him to the prison's care and separation unit for a while, but he declined. They agreed to review the situation after the documentary was screened. On 29 August, a manager asked two prisoner wing representatives to let staff know if they heard of any threats about a prisoner who was about to be the subject of a television documentary, but did not name him. None of the officers or prisoners that we spoke to said that they identified any change in him over the next few days that would have led them to be concerned about him.

4. During a morning roll check, one morning in September, an officer saw the man apparently unconscious with a cord around his neck attached to the end of his bed. He radioed a medical emergency code, but did not go into the cell until a colleague arrived and opened the door. They cut the cord from around his neck and laid him on his bed. His body was cold to the touch. A nurse arrived and began cardiopulmonary resuscitation. Control room staff did not call an ambulance until nine minutes after the code blue was called and it took the ambulance staff 17 minutes to get from the prison gate to the cell. Paramedics arrived at around 6.20am but it was apparent that he had died. At 6.22am, the paramedics pronounced his death.

5. We are satisfied that it would have been very difficult for staff to have foreseen the man's action and taken action to have prevented his death. However, we are concerned that an officer did not go immediately into the cell when he found him unresponsive with a ligature around his neck. There was also a delay in calling an ambulance and getting paramedics to the cell quickly. While it does not appear that these delays would have affected the outcome for him, in other circumstances this could be crucial and is a matter we have raised with Whitemoor before. We also note that the nurse felt obliged to attempt resuscitation even though she considered that he had been dead for some time. This is a matter about which staff need guidance. We make three recommendations.

THE INVESTIGATION PROCESS

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

7. The investigator visited Whitemoor on 5 September and met the Governor and other senior managers, and staff involved in the man's care. He visited the wing where he had lived and obtained copies of his prison and medical records.

8. NHS England commissioned a clinical reviewer to review the man's clinical care in prison. The investigator and clinical reviewer interviewed 16 members of staff and five prisoners during the investigation, some jointly. The investigator informed the deputy governor about his preliminary findings.

9. The investigator informed HM Coroner for North and East Cambridgeshire of the investigation. We have sent the Coroner a copy of this report.

10. One of the Ombudsman's family liaison officers contacted the man's sister to inform her of our investigation and to ask her if she had any relevant issues she wanted the investigation to cover. She did not identify any specific matters for the investigation to take into account. She received a copy of the draft report. As part of their feedback to this report, the family said that they had submitted a list of questions to the coroner. We have not received these questions.

11. The man's family received a copy of the draft report. They pointed out some factual inaccuracies and omissions. This report has been amended accordingly. They also raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP WHITEMOOR

12. HMP Whitemoor is a high security prison, which holds over 450 men serving long sentences. NHS East Anglia commissions healthcare services. Cambridgeshire and Peterborough NHS Foundation Trust manage the prison's mental health provision.

13. The prison healthcare centre includes a nine bed in-patient unit. The prison directly employs nurses, who provide a twenty-four hour service. Medacs provide the GP service and there is an on-call service for out of hours cover.

Her Majesty's Inspectorate of Prisons

14. The most recent inspection of Whitemoor was in January 2014. Overall, inspectors found Whitemoor to be a safe, respectful and purposeful prison, which provided opportunities for prisoners serving long sentences to address their offending behaviour. The Inspectorate assessed staff-prisoner relationships had improved from previous inspections and most prisoners said they had a member of staff they could turn to for help. Inspectors found that prisoners identified at being at risk of self-harm were generally well supported. Management of healthcare services was found to be reasonable but inspectors noted some substantial staffing challenges. The GP service was assessed as clinically sound but many prisoners did not feel they were listened to.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its latest annual report for 2013-14, the IMB noted that the safer prisons team was dedicated and provided a comprehensive programme of support. However, the IMB was concerned that staff had not been released for essential safer custody training, as there were insufficient trained assessors.

Previous deaths at Whitemoor

16. There have been two previous self-inflicted deaths at Whitemoor since 2010. The most recent death, in September 2013, was of a man who had been a friend of the man and was also serving a life sentence. In that case, we made recommendations about officers going into cells in an emergency at night and about effective response to medical emergencies. The same issues arose in this investigation.

KEY EVENTS

17. On 13 August 2009, the man was remanded to HMP Peterborough accused of the murder of two people. His co-defendant was a 15 year old girl, and her father was one of the victims. He had been in prison before and had a history of alcohol and substance misuse. He was convicted of murder on 4 August 2010 and received a mandatory life sentence.

18. On 22 November, the man transferred to HMP Whitemoor. During his time there, he received treatment for hepatitis C and osteoarthritis of the hip.

19. On 29 July 2012, a custodial manager spoke to the man after receiving information that suggested that he might be at risk of assault from another prisoner after there had been some publicity about his offence. He said he did not want to move to the prison's segregation unit for his own protection and said that he felt safe.

20. From 31 July, staff monitored the man as a potential victim under the prison's unacceptable behaviour strategy, after a documentary was shown about his offences. Officers decided to support him under the behaviour strategy as they considered that he was at risk from others, but not to himself. No prisoners had made any direct threats to him, but officers were concerned by some comments prisoners had made. He said that he felt safe in his current location and did not want to move.

21. At a review on 13 August, the man said he had no problems on the wing and he had no issues with any other prisoners. An entry in the wing observation book drew attention to a letter another prisoner had sent out, which said that prisoners on the wing were ignoring him. Officers on the wing had not seen any signs of this. He agreed that he would let officers know if he needed support. The staff ended the monitoring process on 27 August, as there had not been any further issues.

22. On 11 September 2013, another prisoner, who was a friend of the man, killed himself. The man's personal officer wrote that the man was upset but accepted that such events happened.

23. On 28 February, a psychology interventions facilitator assessed the man's suitability to join the Thinking Skills Programme (TSP, which helps prisoners develop thinking and emotional skills to help prevent them offending in the future). He engaged well with the assessment and she added him to the waiting list for the programme.

24. During the early months of 2014, officers' entries in the man's prison record were generally positive. However, on 30 May, an officer recorded that he had shown a poor attitude towards his job as a wing painter and a superior attitude towards another painter. On 2 June, an officer recorded that he appeared to be finding excuses for not carrying out his painting duties and often played snooker when he should have been working. He recorded that he would warn him that his behaviour could cost him his job and lead to a review of his

enhanced privileges status. The officer did not make any further entries about this issue.

25. On 11 July, the man became upset when he thought some medication for a worm infection was not available. A nurse quickly resolved this issue. On 16 July, he attended a hepatology clinic appointment at hospital. His escort officer recorded that a nurse had told him that the prison was being unhelpful about his antiviral hepatitis treatment. He was angry about this, but she noted that he remained polite. A prison doctor saw him when he returned from hospital and recorded that that he would be receiving a new antiviral medication from December 2014. He referred him to the mental health team because he said he was not sleeping well.

26. On 24 July, the man attended his first one-to-one session for the Thinking Skills Programme. The course facilitator recorded that he fully engaged and was open about his offending. On the same day, a mental health nurse saw him. The nurse asked him if he had any issues about anxiety or depression, which were preventing him from sleeping. He said this was not the problem, but he wanted medication to help him sleep because of "the boredom in this place". He said he was only sleeping for a couple of hours but had exaggerated his symptoms for the prison doctor. The nurse recorded that he was not suffering from mental health problems. He told the clinical reviewer that he had said that he did not have any thoughts of suicide or self-harm.

27. On 29 July, an officer, who was acting as a reserve for the man's personal officer, noted in his prison record that he had not raised any issues with him during the week and that they would speak again when the officer had finished a run of night shifts. On 5 August, the officer recorded that he had spoken to him briefly and he had raised no concerns.

28. On 6 August, the man attended his second individual session of the Thinking Skills Programme. The course facilitator noted that he was fully engaged throughout the session, had a positive attitude and had tried to develop and learn the skills discussed during the session. The course facilitator made similar comments after a further session on 20 August.

29. On 21 August, an officer spoke to the man about the Thinking Skills Programme and they discussed a negative entry on his record about previous poor behaviour, which he wanted to challenge. This was the last entry in his prison record.

30. On 26 August, the man told an officer that a television documentary about his offence was going to be broadcast on 3 September. He was concerned that prisoners might mistakenly think that he had been in a relationship with his co-defendant, who was 15 years old at the time of the offence, and then threaten him because of it. The officer offered to move him to the segregation unit for a while, but he declined. They agreed to review the situation the morning after the documentary was shown.

31. The officer made an entry about this in the wing observation book, submitted a security intelligence report and spoke to a supervising officer (SO) on A Wing. The SO told the investigator that he supported the officer's actions as he had a good rapport with the man, and that they did not have any concerns that he might try to harm himself.

32. On 29 August, the man told the course facilitator about the documentary and asked if, in the circumstances, he could be allowed not to talk about his offences during a Thinking Skills Programme group session that day. The course facilitator agreed and told him only to get involved in exercises he found comfortable. During the session, he interacted well with other members of the group and his mood appeared upbeat. The course facilitator told the investigator he did not think it was necessary to note anything in his prison record or tell officers on A Wing that he had not wanted to discuss his offences in front of other prisoners. He said he had had no concerns about him at the time.

33. A custodial manager on A Wing recalled that prisoners and staff had openly discussed the forthcoming documentary. In a statement to the Governor written after the man's death, he said that the programme was also mentioned at a senior management meeting on 29 August. That afternoon, he chaired a wing representatives meeting with another member of staff and two prisoners. At the end of the meeting, he mentioned that a documentary about a prisoner would be shown and asked the prisoners to help staff if they heard any negative comments from other prisoners. He did not name the man and the issue was not recorded in the minutes of the meeting.

34. After the meeting, one prisoner told an officer that he knew that the documentary was about the man. The officer noted this in the wing observation book and completed a security intelligence report, as he was concerned that the man's personal situation had been discussed at a consultation meeting. The custodial manager then wrote in the wing observation book that information about the documentary was in the public domain and that prisoners on the wing had been discussing it. He had mentioned it to the wing representatives (without naming the man) to encourage them to report any concerns about him to staff. He did not speak to the officer about his entry.

35. The custodial manager told the investigator that he did not speak to the man specifically about the documentary, but asked him how he was, when he next saw him. He said he was fine and asked about paint supplies. He did not have any concerns that he might be considering suicide or self-harm.

Sunday 31 August 2014

36. On the morning of Sunday 31 August, one of the man's friends was working with a SO helping to get the lunch ready to serve. The prisoner suggested that they should not issue jam (which prisoners sometimes mix with boiling water to scald someone badly). He told the SO that no one had made any direct threats to the man but he was not sure how some of the younger prisoners would react to the documentary. He told the SO that he did not think that the man was in

any immediate danger. The SO noted this in the wing observation book and submitted an intelligence report. He did not speak to the man about it. The prisoner told the investigator that he had wanted to make sure that officers prevented any possible action against his friend after the documentary was shown.

37. An officer saw the man at around 11.50am when he collected his lunch. He saw him again when he collected his next meal later that afternoon. The officer said that he had asked him how he was and he had replied, “All good thanks”.

38. An officer said that he had spoken to the man throughout the day and he had given no indication of being down. He had played snooker during the day and the officer was not concerned about him.

39. A prisoner told the investigator that the man had visited his cell during the day and borrowed tobacco and cigarette papers. He saw him for the last time at the servery that evening when he gave him a high five and squeezed his hand. He said that the man had appeared fine throughout the weekend.

40. Another prisoner told the investigator that the man had visited him at around 4.30pm. He was playing a computer game so he did not fully engage with him, but he did not think anything was amiss with him. Just before they were locked up for the evening, the man also visited another prisoner and they sat in his cell smoking. The prisoner told the investigator that the man had looked a little tired. As they finished their cigarettes, staff had called out for prisoners to return to their cells. The man said that he would see the prisoner the next day and shook his hand. Although the prisoner had thought that this was unusual, he was not concerned about him, as he had been following his usual routine throughout the weekend.

41. Just before he was locked in his cell, the man told his neighbour that he might make some noise during the night while he cleaned his cell. The prisoner told the investigator he had not known him to clean his cell at night before but did not think further about this. He did not see any sign that he was considering suicide or self-harm or suicide and did not hear any noises from his cell that night.

42. An officer locked the man in his cell, at about 4.45pm. The officer told the investigator that he did not have any concerns about him.

43. An officer started a night shift on A Wing at around 8.00pm. Colleagues from the earlier shift handed over to him and he then did a roll check to confirm that all prisoners were present and correct in their cells. The officer told the investigator that the man was reading in his cell when he checked. He did not use his cell bell during the night.

44. Shortly before 5.30am, the officer began a morning roll check. He started on the ground floor and then moved to the first floor. He checked that the man’s cell door was locked, but then saw him on his bed facing away from the door in a seated position but leaning back. He had a cord tied around his neck, which

was fastened to the end of the bed furthest from the door. At 5.31am, the officer radioed a code blue emergency (to indicate circumstances such as when a prisoner is unconscious, not breathing or hanging and that an emergency ambulance and immediate medical assistance are required). He then went to the wing office to phone the control room with more information before going back to the cell.

45. Most officers in prisons at night do not carry a full set of keys, but have a cell key in a sealed pouch for use in an emergency. The officer went back to the office again and asked a SO in the emergency control room for permission to go into the cell using his emergency cell key. The SO said that it was up to the officer to decide whether to go into the cell or wait for help. The officer decided not to go in. He told that investigator that he was unsure about the situation inside the cell.

46. An assistant night orderly officer was the first member of staff to arrive on A Wing and join the officer. She opened the cell door and (according to the control room log) called the control room at 5.35am and asked them to call an ambulance. The ambulance service logged a call to them from Whitemoor at 5.40am, and an entry in the prison's control room log at 5.42am noted that two vehicles were on their way to the prison.

47. The SO and officer cut the ligature, which was made from a dressing gown cord, from the bed and the man's body leant back to an almost lying position. The cord was still tight around his neck and the SO pulled it away so that the officer could cut it. They said that the man's face was a deep purple and red colour, his tongue was blue and his body was cold. The SO could not find a pulse in his neck. A nurse arrived with emergency equipment. Although she thought that the man was clearly dead, she began cardiopulmonary resuscitation as she thought she was obliged to. The SO, officer and a custodial manager, who had also responded to the emergency, assisted. The nurse attached an automated external defibrillator to the man. The defibrillator did not detect a shockable rhythm and staff continued cardiopulmonary resuscitation.

48. An ambulance arrived at the prison at 6.03am. However, paramedics did not arrive on the wing until 6.20am, a delay of 17 minutes, caused mostly by staff having to unlock and lock five gates on the way. In his witness statement, a paramedic wrote that the man was on his back with no signs of life and rigor mortis was present. The paramedics pronounced death at 6.22am.

49. The man had left a note for staff. He apologised to the officer who found him, and said that Whitemoor was a good jail to him and his death was not the prison's fault. At the end of the note, he apologised to his friends for not telling them how he was feeling or what he intended to do and said that nothing could have stopped him. He also left a letter for his sister, in which he said he was innocent of his offence, but felt very alone in prison and thought that his life in prison would be a "living hell" after the television programme was shown. He said that killing himself was the only way he could find peace.

Contact with the man's family

50. The prison's family liaison officer and a prison manager visited the man's sister, at 11.15am, to inform her of his death and to offer condolences and support. The prison kept in contact with her and offered financial help towards the funeral expenses, in line with national guidance. The funeral took place on 17 September 2014.

Support for staff and prisoners

51. A prison manager debriefed the staff who had been involved in the emergency response and offered them the support of the prison's care team. Staff at the debrief said that they had been anxious about the time it had taken the ambulance to arrive.

52. The prison issued notices to staff and prisoners informing them of the man's death. Officers and members of the chaplaincy supported prisoners. Staff reviewed prisoners assessed as at risk of suicide or self-harm, in case they had been adversely affected by his death.

Post-mortem and toxicology reports

53. A post-mortem examination recorded the cause of death as asphyxiation due to ligature around the neck. No trace of drugs or alcohol was present during a toxicology report, except for paracetamol, which was found at therapeutic levels.

ISSUES

Assessment of risk of suicide or self-harm and threat of violence against the man

54. In 2012, staff managed and supported the man as a potential victim of bullying and threats as they were concerned that other prisoners might react against him after television coverage of his offence. Officers ended the monitoring arrangements after a month. There is no record that other prisoners targeted him because of the television programme, or any indication that he was at risk of suicide or self-harm at the time.

55. Two years later, the man told an officer that a documentary about his offence was about to be broadcast. The officer submitted a security intelligence report and reported the conversation to his manager. He was not so anxious that he wanted to move from the wing and the staff agreed to review his position after the programme was shown.

56. A custodial manager spoke to trusted prisoner wing representatives about the television programme as he hoped that they would alert staff if they heard of any impending threat to the man. We are satisfied that he did not name him, although it is clear that it was obvious to the other prisoners who he was talking about. An officer suggested to a SO that some prisoners might attack the man as a result of the programme, but he said that he did not have specific knowledge about any threats. The SO submitted a security report about this.

57. A prisoner who had known the man for over three years, told the investigator that other prisoners had taunted him about his offence and in particular about the age of his co-defendant since shortly after he arrived at Whitemoor. He said that this was low-level abuse, but, as far as he knew, the man did not receive direct threats from other prisoners generally took the comments on the chin. He said that he had spoken to him and said that if he was worried he could ask to go to segregation unit or apply for a transfer, but he had said that he was fine. Other prisoners also said that they did not see any indication that he had any thoughts of suicide. He wrote in his note to staff that he had not told his friends.

58. We have considered Whitemoor's response to the man's concerns about the forthcoming broadcast of the documentary. There is no evidence that he was threatened by other prisoners, and officers submitted intelligence reports when they received information. An officer discussed the situation with him and they agreed they would review his position after the programme had been shown. Staff and other prisoners did not detect any signs that he might be thinking of killing himself. We are satisfied that staff could not reasonably have foreseen his actions and we consider that they took appropriate action to address his concerns.

Clinical care

59. The clinical reviewer was satisfied that healthcare staff had no indication that the man intended to take his own life. She identified a number of issues which the Head of Healthcare will need to address. In particular, she noted that he had waited too long before starting treatment for hepatitis C and that he had not received treatment equivalent to that he could have expected in the community. However, she did not find any link between the delayed treatment and his death.

Emergency response

60. At night, officers on wings have a cell key in a sealed pouch for use in an emergency. Prison Service Instruction 24/2011, which covers management and security at nights, states that staff have a duty of care to prisoners, to themselves and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment.

61. An officer called a code blue but then went to the office to telephone the control room to give more information. He returned to the cell, but then went back to the wing office again to ask for permission to enter the cell. A SO told him it was his decision. The officer decided to wait for other staff to arrive before he opened the cell. An assistant night orderly officer arrived very shortly afterwards.

62. The officer knew that the man was in a single cell, had no history of causing problems for staff, had a ligature around his neck and was not moving. While it is a judgment call and difficult for staff in such situations to make immediate decisions, when someone is in an apparent life-threatening situation, it is essential to act quickly. Unless there are evident risks, we would normally expect staff to go into a cell as soon as possible, in case there is a chance of saving someone's life. In this case, there was an obvious risk to life and, although in this case it would not have affected the outcome, we consider on balance that the officer should have gone in to the cell as that risk outweighed any potential risk to himself. It appears that if the SO had agreed, he would have gone into the cell on his own.

63. After a death at Whitemoor in 2013, we made a recommendation to the Governor about the circumstances in which staff can go in to cells at night without authority. We make the following recommendation:

    The Governor should ensure that managers and staff understand that, subject to a personal risk assessment, staff should enter a cell at night when there is potentially a risk to life.

64. The officer immediately radioed an emergency code blue when he discovered the man with a cord around his neck. The control room logged the emergency code at 5.31am, but they did not call an ambulance until after the assistant night orderly officer asked for one at 5.35am. (The ambulance service recorded that they had received a call at 5.40am.) Paramedics arrived at the prison at 6.03am, but took another 17 minutes to reach the cell. Although, in this case, this did not make a difference to the outcome, we consider that this was unacceptably long. The SO who was in charge of the control room at Whitemoor on 1 September, told the investigator that an officer and dog handler escorted the ambulance through several gates, opening and closing the gates as they went.

65. It is apparent that Whitemoor needs better night contingency arrangements to allow ambulances swifter access to wings. PSI 03/2013, Medical Emergency Response Codes, contains a mandatory provision that prisons should have local protocols which "Prevent any unnecessary delay in escorting ambulances and paramedics to the patient and discharging them from the prison (with or without the patient). This must include procedures for admitting and discharging ambulances during the night state".

66. PSI 03/2013 also requires that local protocols have instructions on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that an ambulance is called immediately when a medical emergency is called over the radio network. It explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies. Whitemoor's emergency response protocol contains an instruction that the control room should call an ambulance immediately, but this was not done.

67. We have made a previous recommendation about this. In its action plan, the prison said it had reviewed and updated the policy on medical emergencies and circulated it to all staff. This action was shown as having been completed by 30 May 2014, but in this case, the control room still did not follow the policy.

68. Although it appears that the delays in the emergency response would not have affected the outcome for the man, it is crucial that all staff follow the agreed emergency procedures in order to give prisoners the best chance of survival in a medical emergency and that there are no delays in getting ambulances to prisoners. Managers need to take active steps to ensure that all staff understand the emergency procedures. We make the following recommendation:

The Governor should make active efforts to ensure that all prison staff understand their responsibilities during medical emergencies, that the control room calls an ambulance immediately an emergency code is called and that there are no unnecessary delays in ambulances reaching prisoners.

Resuscitation

69. A nurse responded to the emergency call on 1 September. She decided to attempt resuscitation even though she considered that it was apparent that the man had been dead for some time. She believed she was obliged to attempt resuscitation, as she was not qualified to recognise death. Although she had received annual resuscitation training, this had not included information on the circumstances when resuscitation should not be attempted because it would be futile.

70. We consider that it was not necessary to attempt to resuscitate the man. European Resuscitation Council Guidelines 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 including the presence of rigor mortis. More recently, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 about making appropriate decisions about resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of each individual's situation. These decisions should never be dictated by 'blanket' policies. Attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

    The Governor and Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate.

RECOMMENDATIONS

1. The Governor should ensure that managers and staff understand that, subject to a personal risk assessment, staff should enter a cell at night when there is potentially a risk to life.

2. The Governor should make active efforts to ensure that all prison staff understand their responsibilities during medical emergencies, that the control room calls an ambulance immediately an emergency code is called and that there are no unnecessary delays in ambulances reaching prisoners.

3. The Governor and Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate.

ACTION PLAN					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Governor should ensure that managers and staff understand that subject to a personal risk assessment, staff should enter a cell at night when there is potentially a risk to life	Accepted	All staff to be reminded via a Staff Information Notice that subject to a personal risk assessment staff should enter a cell at night when there is a risk to life. The notice will provide additional guidance so that staff are able to make an informed decision. This staff information notice will be issued personally to all night patrols; it will be included in each wing's night folder; it will be highlighted on the establishment's daily briefing sheet for a specified time period, and it will be mentioned at each daily wing briefing for a two week period.	Head of Residence 10 April 2015	
2	The Governor should make active efforts to ensure that all prison staff understand their responsibilities during medical emergencies, that the Control Room calls an ambulance immediately an emergency code is called and that there are no unnecessary delays in ambulances reaching prisoners.	Accepted	As per PSI 03/2013, Medical Emergency response codes are in place. The Local contingency plans for Code Red/Blue updated. A Staff Information Notice has been re-issued to inform all staff of the medical emergency response instruction and their responsibilities during medical emergencies. The local emergency response procedures will be reissued. All Control Room Senior Officers will be met with to ensure that they know either medical code requires an immediate ambulance request, and that	Head of Operations 31 March 2015	

			adequate information must be provided to the Ambulance Service. The process for the entry of an ambulance and paramedics into the establishment during night state will be reviewed.		
3	The Governor and Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate.	Accepted	All Healthcare staff have been advised of the European Resuscitation Council Guidelines (2010) which state: "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 including the presence of rigor mortis. In October 2014, the British Medical Association (BMA), Royal College of Nursing RCN and Resuscitation Council issued new guidance on making decisions about attempting cardiopulmonary resuscitation (CPR). NOMS Equality, Rights and Decency Group met with NHS England colleagues in February 2015 to discuss the guidance. Work is ongoing to agreed the content of a note to issue to prison staff, later this year. To ensure staff are confident in this area, all healthcare staff received Basic Life Support Training from Human Touch Ambulance Service on the 28/1/2015. All current Healthcare Staff, Mental Health In-Reach staff and Inclusion staff transferring to Healthcare will attend the	Governor/Head of Healthcare 31 May 2015	

			Northamptonshire Healthcare foundation Trusts (NHFT) Induction Programme. This induction includes further training on Basic Life Support, which will ensure that staff are aware of current NHS advice and practices.		