Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Murphy, a prisoner at HMP Norwich, on 29 May 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Anthony Murphy was found hanged in his cell at HMP Norwich on 29 May 2015. He was 51 years old. I offer my condolences to Mr Murphy's family and friends.

Mr Murphy killed himself less than two weeks after being recalled to Norwich prison. Although he had a number of underlying risk factors for suicide and self-harm, I recognise that these would not necessarily have been sufficient in themselves to alert staff that he needed monitoring when he arrived. When he later became upset during consultations with nurses and prison and probation staff about his personal circumstances, Mr Murphy assured them he would not harm himself and said he could cope. As he had spent a considerable amount of time in prison and had no history of self-harm the staff were satisfied by that. In fact, Mr Murphy had cut his wrists a few days after arriving at the prison, but had concealed this from staff.

It is very difficult to prevent someone who has made a determined decision to kill themselves from carrying that out and I do not consider that prison staff could have predicted or prevented Mr Murphy's actions. Although it would not have affected the outcome for Mr Murphy, the investigation found some confusion about emergency procedures, which the prison will need to rectify.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2016**

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Summary

Events

1. In 1993, Mr Anthony Murphy was sentenced to 16 years imprisonment for aggravated burglary and common assault. He had been under the care of mental health teams in a number of prisons and was diagnosed with post-traumatic stress disorder (PTSD) relating to events during his childhood. There is no record that Mr Murphy had any history of self-harm in prison.

2. In January 2013, Mr Murphy was released on licence but, in June 2013, he was recalled to prison after committing further offences. In January 2015, he was released on licence again. On 15 May, he was arrested and charged with burglary. His licence was revoked and he arrived at HMP Norwich on 16 May.

3. While he was in police custody, Mr Murphy was given some upsetting family news. In addition, he thought his partner had a terminal illness. He did not mention these matters when he arrived at Norwich.

4. About three days after he arrived at Norwich, Mr Murphy apparently cut his wrists. He asked two close friends to dress the wounds and told them not to tell officers. Mr Murphy was upset when he spoke to a probation officer and a mental health nurse about his personal circumstances, but said that he was able to cope and did not need further support. The staff recognised that Mr Murphy was anxious about his family but did not consider he was at risk of suicide or self-harm.

5. At 5.20am on 29 May, officers opened Mr Murphy's cell, as he had blocked the door observation panel and did not respond. They found that Mr Murphy had hanged himself. They called an emergency and began to try to resuscitate him. The control room called an ambulance immediately. A nurse responded quickly but had to leave again to get emergency equipment. Nurses continued cardiopulmonary resuscitation and paramedics took over emergency treatment when they arrived at 5.38am. At 6.10am, paramedics recorded that Mr Murphy had died.

Findings

6. Although Mr Murphy had a number of underlying risk factors, we accept that staff did not consider that his level of risk was such that they needed to begin Prison Service suicide and self-harm prevention procedures, known as ACCT, when he arrived at Norwich. Staff recognised his personal problems and offered him

appropriate support subsequently. Mr Murphy seems to have deliberately hidden his self-harm and the level of his distress from staff and we do not consider that they could have predicted or prevented his actions.

7. An officer radioed an emergency immediately when he found Mr Murphy had hanged himself and appropriately began to try to resuscitate him. A member of control room staff called an ambulance straight away. Although we do not consider that this would have affected the outcome for Mr Murphy, we are concerned that after that there appeared to some confusion about emergency procedures. A nurse did not bring an emergency bag to the cell and was surprised that an ambulance had been called before a nurse had assessed Mr Murphy. The investigation found that officers often used emergency codes to call healthcare staff urgently rather than for genuine life-threatening emergencies. This means that nurses and the control room do not always respond in line with the national instructions and Norwich's local emergency protocol.

Recommendation

- The Governor and Head of Healthcare should ensure that all staff understand the need to use emergency medical codes in line with PSI 3/2013, that staff respond with appropriate emergency equipment and that control room staff call an ambulance immediately an emergency medical code is received, without waiting for further confirmation.

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The Investigation Process

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

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

10. The investigator visited Norwich and obtained copies of relevant extracts from Mr Murphy's prison and medical records. He and the clinical reviewer jointly interviewed nine members of staff at the prison in June 2015. He also interviewed two prisoners.

11. We informed HM Coroner for Norfolk of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Murphy's partner, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Murphy's partner asked us to clarify whether Mr Murphy had received appropriate help for his mental health problems, whether he had received his prescription medication appropriately and whether any delays in receiving medication would have adversely affected him.

13. Mr Murphy's family received a copy of the initial report. Mr Murphy's family said that they disputed the accuracy of some comments made about Mr Murphy by prison staff, but no other comments to make.

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Background Information

HMP Norwich

14. HMP Norwich is a multi-function prison, which predominantly serves the courts of Norfolk and Suffolk. The prison holds up to 769 men. Virgin Care provides healthcare services.

HM Inspectorate of Prisons

15. In the report of the most recent inspection of Norwich in August 2013, inspectors noted that, since a critical inspection in 2012, the prison had improved in some important areas. However, they described first night procedures on all wings as potentially dangerous; not all prisoners had first night interviews and some were done by other prisoners. Although self-harm incidents had reduced, there was evidence of under-recording. A high number of prisoners were on ACCT suicide and self-harm prevention procedures.

16. Inspectors also noted that staff-prisoner relationships were courteous but lacked depth and quality. The personal officer scheme was ineffective. Mental health services were good.

Independent Monitoring Board

17. Each prison in England and Wales 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 most recent annual report for the year to February 2015, the IMB noted that they were concerned about inconsistent ACCT entries, and the failure of the personal officer scheme, although they recognised that most people tried hard to do a good job. The IMB considered that mental health provision, under a new contract covering both primary and secondary services, had improved dramatically with a staffing increase under dedicated and capable leadership.

Previous deaths at HMP Norwich

18. Mr Murphy's death was the seventh apparent self-inflicted death at Norwich in the last three years. There were no significant similarities with the circumstances of the other deaths, although we have previously made a recommendation about the placement of emergency medical bags.

Assessment, Care in Custody and Teamwork

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19. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. 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. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

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Key Events

20. In 1993, Mr Anthony Murphy was sentenced to 16 years in prison for aggravated burglary. He had been under the care of mental health teams in a number of prisons and was diagnosed with post-traumatic stress disorder (PTSD) relating to events during his childhood. Mr Murphy had no history of self-harm in prison.

21. In January 2013, Mr Murphy was released on licence, but was recalled to prison in June 2013, after committing further offences. Mr Murphy was released again on 2 January 2015 and lived at Lightfoot House Approved Premises in Ipswich. Mr Murphy's offender manager saw him weekly and said that Mr Murphy was open with him and that they had a positive relationship.

22. On 20 April, Mr Murphy moved to shared supported housing as part of a planned move. The offender manager said that he appeared to be settling in well but was worried about his partner. He said that Mr Murphy appeared stable, always kept his appointments, and did not cause him problems. He said that Mr Murphy appeared to be pleased to be in the community and moving on with his life. There is nothing in Mr Murphy's probation record to suggest that he was ever considered at risk of suicide or self-harm.

23. On 15 May, Mr Murphy was arrested and charged with aggravated burglary. While he was in police custody, officers gave him some upsetting information about a family member. A duty GP saw him and officers completed a detained person medical record, which noted that he had been given upsetting information. The form was passed to court staff on 16 May, along with his Person Escort Record (PER) and both forms were later passed to reception staff at HMP Norwich. On 16 May, Mr Murphy was remanded to Norwich. He had been at Norwich before.

24. An officer booked Mr Murphy in and completed basic reception tasks. The officer told the investigator that he knew Mr Murphy but did not recall much about how he had seemed when he arrived. At an initial health screen, a nurse recorded that Mr Murphy had brought in prescribed medication, omeprazole (for gastric reflux) and tramadol (for hip pain). Mr Murphy continued to receive the medication in prison. The nurse noted that Mr Murphy had no recorded incidents of self-harm, and that he was calm and polite. The nurse said that he usually saw all documents received in reception, but did not remember seeing the detained person medical form from Mr Murphy's time in police custody.

25. Mr Murphy told the nurse that he had previously received treatment from mental health staff in prison including talking therapies. He said he had been prescribed fluoxetine for depression but had not taken it since 2012, as he did not like the way it made him feel. Mr Murphy said that he had developed other coping strategies to help him manage his emotions, which he found worked. (He had previously spent five years at HMP Grendon, which is run on psychotherapeutic principles.) He said that he would seek support from staff if he thought it was necessary, but he felt mentally stable. The nurse referred him to the GP to discuss his prescribed medication, and for a mental health assessment. None of the staff in reception considered that Mr Murphy was at risk of suicide or self-harm.

26. An officer conducted a first night interview with Mr Murphy. (This includes standard questions about risk of suicide and self-harm and allows the prisoner to raise any concerns.) Mr Murphy said that he did not need a full induction as he had been released from prison just a few months earlier. She told the investigator that she knew Mr Murphy from previous sentences and got on well with him. She said that he did not mention anything about self-harm and that she did not identify anything to suggest that he was at risk of suicide or self-harm. She said that she would expect reception staff (including the nurse) to pass on any concerns, if they had any.

27. Mr Murphy was given a cell on A Wing, the first night and induction unit. On 18 May, Mr Murphy attended a secondary health screen with a nurse. The nurse told the investigator that Mr Murphy seemed fine and there was nothing to indicate that he was at risk of suicide and self-harm. He said that the secondary screen rarely lasts more than ten minutes and that he relies on information gained during the initial health screen and any additional documentation, such as a detained person medical form if one is available. He could not recall seeing one for Mr Murphy. As Mr Murphy was prescribed medication, he referred him to the GP and to the mental health team (although this had already been done by the reception nurse).

28. On 19 May, a nurse from the mental health team assessed Mr Murphy using a mental health questionnaire (PHQ-9). Mr Murphy scored 18, which indicates mild depression. On a general anxiety disorder (GAD) rating, Mr Murphy scored 17, indicating that he had some anxiety. She recorded that Mr Murphy became upset when he spoke about the length of time he had spent in prison and that he thought his partner had a terminal illness. She recorded that Mr Murphy did not want to take prescribed medication for depression, and despite his apparent anxiety due to his family situation, did not want additional support from the

chaplaincy or Listeners (prisoners trained by the Samaritans). She recorded that Mr Murphy did not appear vulnerable.

29. The nurse recalled Mr Murphy mentioning he had other family issues. She said that she thought that Mr Murphy felt that he was in the wrong place, and that he should have been at home to support his family. She said that, although her assessments indicated that some depression and anxiety, the templates needed to be completed over a two-week period, as prisoners often scored highly when they first arrived in prison because of the recent change in circumstances. She said that Mr Murphy did not appear depressed and he was naturally anxious about his family rather than suffering from an anxiety disorder.

30. Mr Murphy told the nurse that he had self-harmed when he was a child. He said that he had subsequently had thoughts about self-harm, but did not have any such thoughts currently. Although she recorded that he said he felt that life was not worth living, she told the investigator that she did not think that he was at risk of suicide and self-harm.

31. On 20 May, the manager of the mental health team booked a further review for Mr Murphy on 27 May, which was subsequently changed to 29 May.

32. Mr Murphy had two close friends on A Wing. They told the investigator that around three days after Mr Murphy had returned to prison he had called them to his cell and showed them cuts he had made to his wrists. He asked them to help dress the cuts but did not say why he had done it. They said that they told him to tell a nurse, but he was adamant that he would not. He told them that they would fall out if they reported it. One said that he used a towel and some tape to dress Mr Murphy's wounds and Mr Murphy wore long sleeves so that no one else saw them. He told the investigator that he dressed Mr Murphy's wounds again over the following days and that they had begun to smell. They did not tell anyone about this.

33. Both prisoners told the investigator that they had not seen any evidence that Mr Murphy was under pressure from other prisoners because of drug debts. They said that Mr Murphy could look after himself and was not intimidated easily. One said that Mr Murphy had got some Subutex (an opiate substitute used in drug treatment) from another prisoner, but was not in debt for this. They said that they knew Mr Murphy was worried about family issues, but said that he had not mentioned any intention to harm himself again after he had cut his wrist. They saw no signs that he was suicidal.

34. On 21 May, an officer wrote in Mr Murphy's record that he was struggling because he was very worried about his partner. She told the investigator that she knew that Mr Murphy had concerns, and was upset that he had been recalled to prison. She said that he did not mix with many other prisoners and, as he knew another prisoner well, she had agreed to try to keep him on the wing, but had no particular concerns about Mr Murphy.

35. On 21 May, a prison GP saw Mr Murphy following the referrals made when he arrived. The GP re-prescribed tramadol and omeprazole and did not record any other concerns during the appointment.

36. Later that afternoon, a nurse recorded that Mr Murphy declined a vaccination for Measles, Mumps, and Rubella (MMR). He told the nurse that he had a lot of emotional distress because of family issues and he was feeling inadequate as he could not be with them to offer support. She recorded that Mr Murphy became tearful. She knew that he had a further appointment to see someone from the mental health team and asked if he wanted to see someone sooner. However, he told her that he did not need this as he had been in and out of prisons for years and knew how to manage his emotions.

37. The nurse said that Mr Murphy did not appear suicidal and he did not express any suicidal ideation. She said that she was not concerned about his mood, but she pointed out various support options such as the Samaritans, Listeners on the wing, nurses and the mental health team, who might be able to help him. She did not discuss this conversation with anyone else at the time, although she said that she discussed Mr Murphy informally with another nurse a few days later.

38. On 27 May, Mr Murphy attended a meeting with a probation officer and Supervising Officer (SO), his offender supervisor, about his recall to prison. Mr Murphy spoke openly about the offence that had resulted in his licence being revoked and said that he had let people down. The probation officer recorded that Mr Murphy became emotional at times.

39. The SO told the investigator that Mr Murphy was allocated to his caseload on 21 May. As he and the probation officer worked shifts, the first day they had been able to see him was 27 May. He said that he understood that Mr Murphy had been previously difficult to manage, but he found him quite amiable. He said that they spoke about his recall and why he was back in prison. He thought that Mr Murphy had been open and honest about his circumstances, and had good insight into the seriousness of his alleged offences and that they might attract an

indeterminate sentence. He said that Mr Murphy was upset when speaking about his family.

40. The probation officer made a note about the meeting in Mr Murphy's prison record and the SO took him back to his cell. The SO said that neither he nor the probation officer had discussed Mr Murphy with wing officers or anyone from safer custody as they were not concerned about him. He said that other than when he got upset, Mr Murphy's body language and eye contact were good. He said that he had told Mr Murphy when they got back to his cell that he could put in an application or stop him on the wing if he wanted to speak again.

41. On the evening of 28 May, an officer was on duty on A6 landing. She said that Mr Murphy came to the office and said that he had spoken to his partner and it had been a difficult call, as they had discussed family issues. She said that Mr Murphy said he would not worry about it that night but would call his partner the next morning.

29 May

42. At approximately 5.20am, on 29 May, a night patrol officer began a roll count to check that all prisoners were in their cells. When he arrived at cell A6-25, Mr Murphy's cell, he found the observation panel blocked. He tried to get a response from Mr Murphy and asked him to remove the obstruction but he did not reply. He then called another officer who was also working on A Wing to come to the cell. When this officer could not get a response, he opened the door to check Mr Murphy and found him sitting against the back wall, with a ligature made from torn bedding around his neck, tied to a wooden baton above the window.

43. The night patrol officer radioed a medical emergency code blue (which indicates that a prisoner is unconscious or has other breathing problems). The officer cut the ligature from around Mr Murphy's neck and checked for signs of life. He said that he could feel no pulse, but Mr Murphy was warm and there were no obvious signs of rigor mortis. He immediately began cardiopulmonary resuscitation. Control room staff recorded receiving the code blue at 5.22am and called an ambulance at 5.23am.

44. A nurse responded to the code blue immediately but did not take any emergency medical equipment. The nurse said that he first checked Mr Murphy for any signs of life, and then went down two levels to the ground floor to collect the emergency bag. He told the investigator that he had never taken the emergency

bag immediately in response to a code blue. He radioed to ask another nurse to attend to assist.

45. Another nurse arrived at the cell shortly afterwards. They attached a defibrillator to Mr Murphy, which did not find any shockable heart rhythm. A first responder paramedic arrived at the cell at 5.38am, and an ambulance arrived at 5.41am. The paramedics continued emergency treatment but Mr Murphy did not respond. At 6.01am, the paramedics recorded that Mr Murphy had died.

Contact with Mr Murphy's family

46. At 9.38am, a custodial manager, who acted as the prison's family liaison officer, and the safer custody manager arrived at Mr Murphy's partner's home and informed her of his death. They offered condolences, explained the investigation process and gave their contact details for ongoing support. The custodial manager remained in contact with Mr Murphy's family and the prison offered assistance with funeral costs in line with national instructions.

Support for prisoners and staff

47. After Mr Murphy's death, a manager debriefed the staff involved in the emergency response and offered support. The staff told the investigator that they felt the prison had given them appropriate support.

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

Letters written by Mr Murphy

49. After Mr Murphy's death, staff discovered a number of letters in Mr Murphy's cell addressed to his family, probation officer, the prison governor and the coroner. Mr Murphy said that he was sorry for his actions and he wrote that no one could have known what he intended to do. He wrote about past life experiences, his upset at his partner's medical condition and the fact that he could no longer cause pain to those he loved. Mr Murphy asked that his partner be given a copy of the letter, his watch, and property held at the prison. One of the letters was dated 17 May, the day after he arrived at Norwich.

Post-mortem report

50. The post-mortem examination found that the cause of death was hanging. Toxicology tests found no potentially fatal concentrations of medication.

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Findings

Assessment of risk of suicide and self-harm

51. Prison staff interview new prisoners in reception to assess their risk of suicide and self-harm. They should open an ACCT if they assess that prisoners are at raised risk of suicide and self-harm because of identified risk factors. Prison Service Instruction (PSI) 64/2011 lists a number of factors and potential triggers which increase the risk of suicide and self-harm. Mr Murphy had some of these risk factors and triggers, including recall to prison, a history of depression (although he had chosen not to take antidepressants for some time), upsetting family events and upcoming court appearances. However, the reception nurse noted that that Mr Murphy was calm about his situation, had been in prison before, felt mentally stable and knew how to seek support from staff if necessary.

52. Mr Murphy did not tell reception staff about any family issues and did not have any previous documented incidents of self-harm in prison. His detained person medical record from his time in police custody noted that he had been given some upsetting family news. The reception staff do not seem to have been aware of this, but even with this additional information, we do not consider it would have led to them opening an ACCT or that his other known risk factors were such that staff should have begun ACCT procedures when he first arrived at Norwich.

53. Several members of staff, including from the probation, mental health, and general nursing teams, spoke to Mr Murphy in some detail after he arrived at Norwich, and offered him support. Mr Murphy was sometimes upset about his situation but the staff we interviewed said that after speaking to him about his problems, they did not consider him at risk of suicide or self-harm. They considered that his anxiety about his family, his recall to prison and possible sentence were understandable in his position and that he had assured them that he was able to cope, as he had done for many years in prison. Mr Murphy declined the opportunity to talk to mental health staff and someone from the chaplaincy. None of the staff were aware that Mr Murphy had cut his wrists, until after he died.

54. The letters Mr Murphy left suggest that he had decided to kill himself shortly after he arrived at Norwich. His cut wrists might possibly have been an earlier failed attempt and he made it very clear to his friends that they should not mention this to anyone. Although his friends and the staff he spoke to were aware of the stresses he was facing in his life, none of them considered he was suicidal and

he assured them that he was not. It is very difficult to prevent a person who makes a firm decision to kill themselves from doing so, especially when they indicate otherwise. Mr Murphy wrote that no one could have known what he had intended to do. We are satisfied that Mr Murphy was offered appropriate support after he arrived at Norwich and that the staff could not have anticipated his actions or prevented his death.

Clinical care

55. The clinical reviewer considered that Mr Murphy received at appropriate standard off healthcare at Norwich, equivalent to that he would have expected to receive in the community. He received all his prescribed medication without delay, and the prison appropriately liaised with his community GP about his medication. She noted that some healthcare recordkeeping was not as detailed as it should have been, but was satisfied that two nurses assessed Mr Murphy appropriately and offered appropriate ongoing care.

Emergency response

56. Prison Service Instruction (PSI) 03/2013 requires all prisons to have an emergency code system to effectively communicate the nature of an emergency. Norwich has such as system and when an officer discovered Mr Murphy hanged, he immediately asked the night orderly officer to radio the appropriate emergency code, while he cut the ligature from Mr Murphy. The control room immediately called an ambulance, in line with national and local instructions. The officer started cardiopulmonary resuscitation and continued to do so until nurses arrived. His actions were prompt and appropriate.

57. The PSI states that, when an emergency code is used, a duty nurse should attend immediately with appropriate equipment. The duty nurse did not bring an emergency bag when responding to the call, and told us that he did not usually do so. The other nurse told us that, at night, he usually relied on an officer to collect an emergency bag. Another nurse said that he always took a bag himself. We are not satisfied that healthcare staff are clear about the requirements to take emergency bags whenever a coded emergency is called.

58. Although this was not a problem in this case, we were concerned that there was some confusion about the use of emergency codes. PSI 03/2013 states that emergency codes should be used when there are serious concerns about the health of a prisoner and an emergency ambulance is required. A nurse told us that staff used code red for “anything from minor self-harm” and code blue could

be “anything”. He said that the use of emergency codes often did not result in an ambulance being called, as staff used them to summon healthcare staff urgently rather than for genuine life threatening emergencies. The nurse was aware of the proper procedure but said that the decision whether to call an ambulance was often left until a nurse assessed the prisoner, otherwise too many ambulances would be called when inexperienced officers used emergency coded inappropriately.

59. A nurse told us that when a code blue is called, the orderly officer (in charge of the daily operation of the prison) will usually ask the nurse to assess whether an ambulance is necessary. The duty nurse said that he also usually assessed whether an ambulance was necessary before he asked for one to be called. When he got to Mr Murphy’s cell, he was surprised that one had already been called.

60. We consider that both healthcare staff and officers appear to be confused about their responsibilities when dealing with emergencies. Nurses do not routinely take emergency equipment, officers appear to be using emergency codes for non-emergencies and there is confusion about who should call an ambulance and when. In this case, an emergency code was used correctly and an ambulance called immediately, although a nurse did not take an emergency bag. As officers started CPR immediately, we do not consider this affected the outcome for Mr Murphy. However, prison staff need to understand the importance of using the codes only in defined emergencies as set out in Prison Service Instruction 3/2013 and that misuse is dangerous. It is also crucial that designated staff take emergency equipment with them in response to an emergency code. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff understand the need to use emergency medical codes in line with PSI 3/2013, that staff respond with appropriate emergency equipment and that control room staff call an ambulance immediately an emergency medical code is received, without waiting for further confirmation.