

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Tedros Kahssay a prisoner at HMP Pentonville on 19 January 2016

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## 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*



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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 Tedros Kahssay died at HMP Pentonville on 19 January 2016. He was 29 years old. I offer my condolences to Mr Kahssay's family and friends.

Mr Kahssay was on remand for the murder of his pregnant partner. Although staff knew he was charged with murder, no one at Pentonville identified the circumstances until after he died. There is a close association between the murder of a family member and risk of suicide and, without awareness of the circumstances of the charges against Mr Kahssay, it is difficult to see how staff at the prison could have made an informed decision about his risk. At minimum, I consider that they should have made further enquiries. I am also concerned that, despite the charges and reported history of depression, Mr Kahssay was not referred for a full mental health assessment.

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**

**September 2016**

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# Summary

## Events

1. On 21 December 2015, Mr Tedros Kahssay was remanded to HMP Pentonville, charged with murder. It does not appear that anyone who assessed his risk of suicide and self harm were aware that the victim was his pregnant partner. At initial health assessments, Mr Kahssay said he had a history of depression but did not want any medication for this. A GP had prescribed a short course of sleeping tablets. None of the staff who assessed him considered he was at risk of suicide and self-harm.
2. After his reception, there was little recorded about Mr Kahssay. On 12 January 2016, during a visit, he told a friend that he was fine. He repeated this in a letter to his friend, postmarked 13 January.
3. On 17 January, Mr Kahssay told the wing supervising officer that he felt unsafe and wanted to move to another wing. He would not give further details. The supervising officer arranged a move to another wing but Mr Kahssay told an officer he had changed his mind and no longer wanted to move.
4. Later that day, Mr Kahssay appeared angry and agitated. He banged on his door with a chair and told an officer he wanted to move to another cell. The officer immediately moved him to an empty cell on the same landing, as he believed his cellmate was at risk because of his violent behaviour.
5. At about 5.40am on 19 January, Mr Kahssay was found hanged by a sheet attached to the cell window. Rigor mortis was present, which indicated he had been dead for some time. Despite this, staff tried to resuscitate him. When paramedics arrived, they quickly assessed Mr Kahssay and recorded that he had died.
6. After his death, a prisoner told staff that Mr Kahssay had alleged that his cellmate had done "terrible things" to him. Mr Kahssay's friend received a letter from him, in which he said he was being threatened and might kill himself.

## Findings

7. Mr Kahssay had been charged with murder, which in itself should have indicated a raised risk of suicide. We are concerned that no one who assessed Mr Kahssay's risk of suicide established the details of the charges, which would have suggested he was at very high risk of suicide. We do not therefore consider he had an adequate risk assessment when he arrived at the prison. We also consider that because of the nature of the alleged offence and reported history of depression, he should have had a full mental health assessment.
8. We have not been able to establish exactly what allegations Mr Kahssay had made against his cellmate, as the information was hearsay, from a prisoner who had no direct knowledge of the details. Officers were not aware of these allegations before Mr Kahssay died. There is no actual evidence that Mr Kahssay had been threatened, and it is possible his sudden and erratic change

in behaviour represented a deterioration in his mental health, which was not recognised.

9. As Mr Kahssay's risk of suicide had not been identified when he first arrived at the prison, we consider it would have been difficult for officers on the wing to have spotted that he was at high risk of suicide immediately before his death.
10. The officer who found Mr Kahssay hanged, did not use the expected emergency code, but described the emergency accurately and there was no delay. However, it was apparent that Mr Kahssay had died and staff unnecessarily tried to resuscitate him when it was clearly too late.

## **Recommendations**

- The Governor and Head of Healthcare should ensure that reception staff consider and record all the risk factors of a newly arrived prisoner charged with murder when determining risk of suicide or self-harm including establishing details of the offence.
- The Governor and Head of Healthcare should ensure that prisoners charged with homicide against a family member have an urgent mental health assessment.
- The Governor and Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate.

## The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Pentonville informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
12. The investigator visited Pentonville on 26 January 2016. She obtained copies of relevant extracts from Mr Kahssay's prison and medical records. She watched footage from body worn cameras and listened to the emergency radio message from 19 January.
13. NHS England commissioned a clinical reviewer to review Mr Kahssay's clinical care at the prison.
14. The investigator interviewed thirteen members of staff at Pentonville, three jointly with the clinical reviewer, between January and March 2016. She spoke to two members of staff by telephone. She wrote to two prisoners asking to interview them but they did not reply.
15. We informed HM Coroner for Inner North London district of the investigation. At the time of issuing this report, we had not received the results of the post-mortem examination from the coroner. We have sent the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Mr Kahssay's friend, who acted on behalf of his family, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Kahssay's friend said he was concerned about a letter he had received from Mr Kahssay after his death, in which Mr Kahssay had said he was being threatened. He wanted to know whether this was the case and whether Mr Kahssay had any trouble with other prisoners at Pentonville.

## Background Information

### HMP Pentonville

17. HMP Pentonville is a local prison that holds close to 1,300 young adult and adult men. The prison primarily serves the courts of north and east London.

### HM Inspectorate of Prisons

18. The most recent inspection of HMP Pentonville was in February 2015. Inspectors reported that the prison was running below its agreed staffing level and staff supervision was often poor. The reception area was busy and functional. First night assessments were good but conditions on the first night unit were poor. Most prisoners felt unsafe and levels of violence were much higher than in similar prisons. Relatively few prisoners were assessed as at risk of suicide and self-harm and processes to support them needed improvement.
19. Prisoners' views about staff were poor and the poor physical environment was exacerbated by overcrowding. There had been a significant improvement in support and care for the large number of foreign national prisoners but too little was being done to understand and meet the needs of the large black and minority ethnic population. There was a suitable range of primary healthcare services and some very good secondary mental health care.

### Independent Monitoring Board

20. Each prison 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 latest annual report for the year to March 2015, the IMB reported that its greatest concern was the increase in violence and the number of prisoners who said they did not feel safe. The IMB identified the limitations of the regime and deterioration in the prison environment as contributory factors. The IMB said that the wings were bleak with cramped cells that lacked privacy.

### Previous deaths at HMP Pentonville

21. Mr Kahssay was the sixth prisoner to die at Pentonville since June 2014, and the fourth self-inflicted death. In previous investigations, we found that prison staff did not fully consider risk factors for suicide and self-harm in reception and that reception staff did not have a clear understanding of their responsibilities and the need to share relevant information about risk. We have also previously found that staff unnecessarily tried to resuscitate a prisoner when there were clear signs he was dead.

## Key Events

22. On 21 December 2015, Mr Tedros Kahssay was remanded to HMP Pentonville, charged with murder. The victim was his pregnant partner. Mr Kahssay was born in Eritrea and had come to the UK in 2011, after he had been subjected to violence for his religious beliefs. He was granted asylum and leave to remain in the UK until 2018
23. Mr Kahssay's escort record, which accompanied him from court to the prison, noted that he was charged with murder, was stressed, and needed an Amharic interpreter because he spoke limited English. A Supervising Officer (SO) saw Mr Kahssay for a basic custody screen (an initial assessment to identify current issues and action to resolve them). The SO said he did not remember Mr Kahssay at all. The records of the basic custody screen indicate that Mr Kahssay had no problem reading or writing English and did not raise any other issues. The SO said the interview did not specifically cover risk of suicide or self-harm. The form showed that he was aware Mr Kahssay was on remand for murder but the SO said he was not aware of the details of the charge until after Mr Kahssay died.
24. At an initial health assessment, Mr Kahssay told a nurse that he had no physical health issues but suffered from depression and was not sleeping well. The nurse said Mr Kahssay's English was good. Mr Kahssay had a large scar on his arm, which he said was from an electric shock. He did not give any further details and the nurse did not ask any more about it. The nurse decided to refer Mr Kahssay to the prison GP because of his history of depression and problems sleeping. The nurse did not know what Mr Kahssay had been charged with and did not ask him. He did not assess Mr Kahssay as at risk of suicide or self-harm.
25. A GP examined Mr Kahssay shortly afterwards, and asked him about the burn on his arm. He told her he had received an electric shock about eight years previously. He said he had depression but was not currently taking any medication for it and did not want any. He said he had trouble sleeping, and the GP prescribed him a short course of sleeping tablets. He said he had no thoughts of suicide or self-harm. The GP said she was not aware of the nature of Mr Kahssay's charge at the time and had not asked about it.
26. An officer interviewed Mr Kahssay as part of first night procedures, and to make a cell sharing risk assessment. He said he did not remember Mr Kahssay at all. From the documents, he said it looked like the only information he had was from the escort record and from what Mr Kahssay told him. He did not remember knowing the circumstances of Mr Kahssay's offence but said he was aware that the murder of a family member was a significant risk factor for suicide.
27. The officer assessed Mr Kahssay as suitable to share a cell. He was satisfied that he had been able to communicate effectively with Mr Kahssay. He said he would have used the telephone translation service, if he had had any difficulty, as he was familiar with system because he had been the foreign national officer for several years. He noted in Mr Kahssay's record that he had denied any thoughts of suicide or self-harm. He did not assess him as at risk of suicide.

28. On 22 December, a nurse saw Mr Kahssay for a second day health assessment, a more detailed assessment of mental and physical health issues than the initial health screen. He told the investigator that he did not remember Mr Kahssay very well but noted from the records that he had not presented with any mental or physical health problems and had declined vaccinations and other health interventions. He had not considered that he was at risk of suicide or self-harm.
29. On 23 December, Mr Kahssay completed his induction period on A Wing and moved to a shared cell on G Wing. On 26 December, he moved to another shared cell, also on G Wing.
30. On 30 December, a resettlement officer completed the second part of Mr Kahssay's basic custody screening. Mr Kahssay said he had no issues with housing, education, drugs, alcohol, debt, contact with friends and family or employment. He said his only issue was depression but he was coping well in prison.
31. On 8 January 2016, the records show that Mr Kahssay had an education department induction and an interview with the National Careers Service.
32. On 12 January, a friend of Mr Kahssay's visited him at the prison. He said that Mr Kahssay had seemed well but he did not ask about his situation in prison, as he wanted to distract him and cheer him up. At the end of the visit, Mr Kahssay said, "I know everything". His friend did not have the opportunity to ask him what he meant by that.
33. Mr Kahssay's friend later received a letter from him, postmarked, 13 January. Mr Kahssay said everything was fine and asked for some money. Mr Kahssay tried to call his sister in Ethiopia many times. Most calls connected for only a few seconds, or did not connect at all. On 10 January, the longest call appeared to last two minutes 25 seconds. We do not know the substance of any conversations with his sister as the prison was unable to provide us with the recordings.
34. On the morning of 17 January, a SO said Mr Kahssay told him he felt unsafe and asked to move to another wing. The SO said his English was quite good, and he did not need an interpreter. Mr Kahssay would not tell him why he felt unsafe and he did not appear anxious or distressed. The SO checked Mr Kahssay's record and noted he was Eritrean and on remand for murder. As there were some cells available on D Wing, he decided to move Mr Kahssay as a precaution.
35. The SO asked an officer to tell Mr Kahssay he could move to D Wing and to pack his belongings. However, the officer said that when he told Mr Kahssay he could move, Mr Kahssay said he no longer wanted to. He could not remember anything else about their conversation, or whether he gave any reason for changing his mind.
36. An officer said he was standing opposite Mr Kahssay's cell during the afternoon when he heard banging. He said Mr Kahssay was agitated and angry. He was banging his chair against the cell door and said he needed to move to another cell. His cellmate was in the cell with him at the time, and told the officer that Mr Kahssay had started banging the door with the chair for no apparent reason.

The officer moved Mr Kahssay to an empty cell on the same landing because he was worried that Mr Kahssay's cellmate might be at risk from him.

37. At 9.22am on 18 January, Mr Kahssay telephoned his sister in Ethiopia. The call lasted 50 seconds. We have been unable to listen to this call as the prison said they did not retain the recording. The prison family liaison officer said that he had listened to the call, the majority of which was in Amharic. The part of the conversation in English had nothing of significance in it.

### 19 January 2016

38. Officer A was the night patrol officer on G Wing on the night of 18/19 January. The cell bell records for 18 and 19 January show that Mr Kahssay did not press his cell bell that night. He said that, at about 5.40am, he checked Mr Kahssay for the morning roll count and saw him hanging from the window by a sheet. He immediately radioed for help. He said the night manager had instructed all staff to say what they saw if there was an emergency, so he radioed, 'Prisoner with a ligature round his neck, cell G3-31'. In response, the control room officer called a medical emergency code blue over the radio network and telephoned for an ambulance. The radio log shows that he radioed at 5.38am and the code blue was called immediately afterwards. The control room officer called the ambulance at 5.39am.
39. At night, for security reasons, prison staff on wings do not carry standard prison keys, but have a cell key in a sealed pouch for use in an emergency. Officer A broke the seal on his emergency key pouch but the assist night orderly officer arrived immediately and opened the door with his key first. Mr Kahssay had put something behind the door, which hindered them getting in. After several attempts, Officer A managed to kick the door open, wide enough for them both to go in. They found Mr Kahssay had put his metal-framed chair between the door and the frame of his bed.
40. Officer A held Mr Kahssay up while the assist night orderly officer tried to cut the sheet from around his neck, but it was too tight. They cut the sheet from the window and managed to remove it from around Mr Kahssay's neck when they had lowered him to the floor. They both said Mr Kahssay was stiff, very cold and looked like he had been dead for some time. His arms had contracted into an unusual position and did not move when they laid him on the floor. The assist night orderly officer said he went to the doorway to tell the night manager, who had responded to the code blue, that Mr Kahssay was dead. At this point, nursing staff and Officer B arrived.
41. Nurse A said she was on A Wing when she heard the code blue. As she had recently had a knee operation, she had agreed with Nurse B that in an emergency she would collect the red bag of emergency equipment and Nurse B would collect the heavier green bag of emergency equipment, including oxygen and a defibrillator.
42. Nurse A arrived on G Wing at the same time as Officer B, the night patrol officer from A Wing. The nurse said she could get no response from Mr Kahssay and noticed his hands had stiffened into a claw-like position. She asked Officer B to

begin cardiopulmonary resuscitation by giving chest compressions, while she checked Mr Kahssay for signs of life.

43. Shortly afterwards, Nurse B arrived from F Wing. The nurses attached oxygen and the defibrillator to Mr Kahssay. The defibrillator found no shockable heart rhythm and the nurses continued chest compressions until paramedics arrived.
44. The first response paramedic arrived at the prison at 5.43am, and an ambulance crew of two arrived at 5.46am. London Ambulance Service records show the paramedics arrived at Mr Kahssay's cell at 5.55am and recorded his death at 6.02am. The London Ambulance Service records note that Mr Kahssay had signs of rigor mortis in his jaw and limbs and was "obviously deceased".

### Contact with Kahssay's family

45. At 7.15am, the prison appointed an administrative officer at the prison as their family liaison officer. He contacted Mr Kahssay's solicitor and the police to try to find the contact details for his next of kin. Neither had details so he began calling numbers on Mr Kahssay's prison telephone list. He tried several times to contact Mr Kahssay's friend but got no reply. In the afternoon, he telephoned Mr Kahssay's sister in Ethiopia. The line was busy and would not allow him to leave a voicemail. At 3.45pm, Mr Kahssay's friend called and he informed him that Mr Kahssay had died. Mr Kahssay's friend said he would try to contact his brother in the United States of America, using Facebook.
46. On 21 January, Mr Kahssay's brother told the family liaison officer that his family wanted the prison to liaise with Mr Kahssay's friend. The prison arranged for Mr Kahssay's body to be flown back to Ethiopia, where his family lived. The prison contributed towards the costs, in line with national instructions.
47. After his death, Mr Kahssay's friend received an undated letter from him. The envelope was postmarked 18 January. Mr Kahssay's solicitor gave us a translated version of the letter. In the letter, Mr Kahssay had written:

"Hello how are you, is everything fine? I am in trouble. All things have changed. I am being threatened. So before I decide to commit suicide call immigration and tell them the place and prison I am in. Please. I have now figured out everything. And the other thing is that I will call to human rights activists. I have obtained their number. If I call my lawyer next Monday and he doesn't come, I have decided to take my own decision ... I will call home and explain to them what is going on. I can't do anything more. And they are too worried ..."

48. After Mr Kahssay's death, a prisoner told prison staff that Mr Kahssay had told one of the wing cleaners (a trusted prisoner) that his cellmate had done "terrible things" to him. The prison passed this information to the police, who spoke to the prisoner and Mr Kahssay's cellmate but did not take formal statements. The prisoner, who gave the information, said he had not actually spoken to Mr Kahssay directly. Mr Kahssay's cellmate denied any problems with Mr Kahssay. The wing cleaner refused to talk to the police. We wrote to his cellmate and the wing cleaner, asking to speak to them but they did not reply.

### **Support for prisoners and staff**

49. After Mr Kahssay's death the deputy governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
50. The prison posted notices informing other prisoners of Mr Kahssay'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 Kahssay's death.

### **Post-mortem report**

51. We have not received the full post-mortem report. Toxicology tests detected no alcohol or drugs in Mr Kahssay's body.

# Findings

## Assessment of risk

52. Prison Service Instruction (PSI) 64/2011, (Safer Custody) lists a number of risk factors and potential triggers for suicide and self-harm. Mr Kahssay had some of these risks:
- Violence against another person, especially against family members
  - Childhood adversity (a history of torture)
  - History of depression.
  - First time in prison/early days in custody
53. A charge of murder is a significant risk factor for suicide in itself. The murder of a partner, especially a pregnant one, should have indicated that Mr Kahssay was at very high risk, yet no one identified this when he arrived at Pentonville. Most of the staff who interviewed Mr Kahssay when he first arrived did not remember him at all. Several acknowledged that the records indicated they knew he was on remand for murder but said they did not know the circumstances of his offence.
54. In our Learning Lessons Bulletin on early days and weeks in custody, published in February 2016, we recognised that reception staff, especially those in busy local prisons, have a hugely demanding task. They have to manage large numbers of prisoners, many with multiple risks and vulnerabilities. But to be effective risk assessment must take account of known or readily available information associated with suicide. The assessment process in reception is the best time for risks to be identified and recorded.
55. Prison Service Instruction 7/2015, about early days in custody, requires all newly arrived prisoners to be assessed as part of the reception health screen process to determine whether they are at risk of suicide or self-harm. However, none of the healthcare staff were aware that Mr Kahssay had been charged with murder and none of them asked them about his offence. PSI 7/2015 lists the escort record as part of the information healthcare staff need and we do not consider that healthcare staff can properly assess risk of suicide and self-harm without information about the prisoner's charges or offences.
56. Most of the prison staff interviewed said they were aware that the murder of a close family member is a significant risk factor and that knowing more about Mr Kahssay's offence would have helped identify that he might be at risk of suicide or self-harm. Some said that the police and court staff, who would have known, should have put more detail on Mr Kahssay's escort record. While this would have been helpful, it is clear that most staff knew he had been charged with murder, which is itself an indicator of increased risk. That should have led to further enquiries, including asking Mr Kahssay himself about what had happened. No one attempted to find out the details of the charge and we cannot therefore consider there was an adequate assessment of his risk when he arrived.

57. Even without the details of the charge, Mr Kahssay had risk factors which would have indicated a significant risk, yet there is no evidence that these were considered. All the staff appear to have relied solely on Mr Kahssay's statements that he did not intend to kill himself. We consider that staff should have tried to find out more about the nature of Mr Kahssay's charge in order to assess his risk of suicide and self-harm properly. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that reception staff consider and record all the risk factors of a newly arrived prisoner charged with murder when determining risk of suicide or self-harm, including establishing details of the offence.**

### **Mental health assessment**

58. Part of the consequence of not knowing the details of the charge against Mr Kahssay, is that no one referred him for a mental health assessment. We consider that, as Mr Kahssay had been charged with murder and had reported a history of depression, a full mental health assessment should at least have been considered, as this can be an important safeguard, even if the prisoner is not displaying overt mental health problems at the time. When the homicide involves a close family member we consider a mental health assessment is essential to deal with the possible impact of guilt and bereavement and the very high risk of suicide. Mr Kahssay had been charged with the brutal murder of his pregnant partner and this should have led to immediate concerns about the state of his mental health. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that prisoners charged with homicide against a family member have an urgent mental health assessment.**

### **Mr Kahssay's request to move cell**

59. On 17 January, less than two days before he died, Mr Kahssay asked to move to a different wing. He told a SO that he felt threatened but would not tell him the nature of the threats. Mr Kahssay was offered the opportunity to move to D Wing shortly afterwards but told an officer he no longer wanted to move. Later, in the afternoon, he appeared angry and agitated and asked Officer Kemp if he could move to another cell. An officer moved him immediately because he was concerned that Mr Kahssay might be a threat to his cellmate.
60. We have not been able to establish whether Mr Kahssay told any prisoners why he wanted to move, but he did not give the officers any reason. While further investigation would have been preferable, we understand that Mr Kahssay would not say more to staff at the time. Subsequently, staff were more concerned that Mr Kahssay was a risk to others rather than a risk to himself. We have found no evidence of any threats against him. It is possible that Mr Kahssay's sudden and erratic changes in behaviour represented a deterioration in his mental health, which was not recognised, but there was little to indicate to staff that they should have begun ACCT monitoring.

## Resuscitation

61. Nurse A responded to the emergency call and when she examined Mr Kahssay, she could find no sign of life. She noted Mr Kahssay was cold and his hands had stiffened. Although Mr Kahssay showed clear signs of rigor mortis, she decided to try to resuscitate him.
62. Nurse A told the investigator that she always tries to resuscitate a patient until a doctor or an ambulance crew takes over, because she is not qualified to pronounce death. Nurse B said that although colleagues had told her not to try to resuscitate someone who is clearly dead, she had not received training on this. In our investigation into the previous death at Pentonville, the clinical reviewer suggested that healthcare staff at Pentonville should review training needs about resuscitation when there are clear signs of rigor mortis.
63. We consider that it was not necessary to attempt to resuscitate Mr Kahssay. European Resuscitation Council Guidelines 2010 say that, “Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile ...” The guidelines give 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. Attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased. We repeat the recommendation made in our previous investigation:

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

## Emergency response

64. Prison Service Instruction (PSI) 03/2013 requires prisons to have a medical emergency response code protocol that ensures that an ambulance is called automatically in a life-threatening medical emergency. Although Officer A did not use an emergency code when he discovered Mr Kahssay hanged, he clearly described the nature of the incident and control room staff called a code blue and an ambulance immediately. We are satisfied that there was no delay in the emergency response.

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