Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Darius Lasinskas a prisoner at HMP Huntercombe on 28 April 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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.

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

Mr Darius Lasinskas was found hanged in his cell at HMP Huntercombe on 28 April 2016. He was 26 years old. I offer my condolences to Mr Lasinskas' family and friends.

While staff were aware that Mr Lasinskas was anxious about being transferred to serve the remainder of his sentence in a Lithuanian prison, there was little to indicate he was at imminent and high risk of suicide. I consider it would have been difficult for staff at Huntercombe to have predicted or prevented his actions.

This was the first self-inflicted death at Huntercombe we have investigated and the investigation identified some weaknesses in the emergency procedures at the prison, including calling an ambulance and when to attempt resuscitation.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman **December 2016**

Contents

Summary

Events

1. Mr Darius Lasinskas was a Lithuanian man who had been living in the United Kingdom for approximately six years. On 2 March 2015, Mr Lasinskas was arrested and charged with wounding with intent to do grievous bodily harm. As he was being arrested, Mr Lasinskas stabbed himself in the chest. He was treated in hospital for a four centimetre stab wound and a partially collapsed lung. Three days later, he was released from hospital.

2. On 6 March, Mr Lasinskas arrived at HMP Lincoln. He was monitored under Prison Service suicide and self-harm prevention procedures for one week until staff were satisfied that he had no thoughts of suicide or self-harm. Two months later, Mr Lasinskas was sentenced to four years and six months in prison. On 28 May, he was transferred to HMP Stocken.

3. On 23 June, Mr Lasinskas was transferred to HMP Huntercombe, which holds only foreign national prisoners. Two days later, an immigration officer told Mr Lasinskas that the Home Office wanted to deport him. Mr Lasinskas agreed to be deported and said he did not want to appeal this decision. On 23 July, an immigration officer gave Mr Lasinskas a deportation order and a letter explaining that the UK authorities were considering transferring him to a Lithuanian prison to serve the remainder of his sentence (known as repatriation).

4. On 30 July, a mental health practitioner assessed Mr Lasinskas, who said that he was worried about repatriation and was having trouble sleeping. Mr Lasinskas said that he had no thoughts of suicide or self-harm and he scored low on anxiety and depression screening tools. The mental health practitioner referred Mr Lasinskas to a relaxation class but he did not attend. Mr Lasinskas did not have any further contact with the mental health team.

5. On 13 August, Mr Lasinskas completed paperwork recording that he did not want to be repatriated because he feared for his safety in a Lithuanian prison. On 20 January 2016, the UK authorities notified Mr Lasinskas that they had considered his concerns but planned to proceed with his repatriation. On 24 February, a Lithuanian court notified Mr Lasinskas that he would be eligible for release in June 2017. The same day, Mr Lasinskas completed paperwork to appeal this sentence.

6. On 25 and 26 April 2016, Mr Lasinskas refused to attend work in the gardens. He told an officer that he was upset about his repatriation and just needed some time to get his head around things. Staff did not have any serious concerns about his vulnerability and did not consider beginning suicide and self-harm prevention procedures. On the evening of 27 April, Mr Lasinskas spent time with friends who did not report any concerns about him.

7. At about 7.15am on 28 April, an officer raised the alarm when he found Mr Lasinskas sitting on the floor with a sheet tied around his neck and attached to his cupboard. The first staff to arrive at Mr Lasinskas' cell did not try to resuscitate him, as they were sure that Mr Lasinskas had died. Other staff who

responded to the emergency call decided that, despite the presence of rigor mortis, they should attempt resuscitation.

8. A member of staff was working alone in the control room when the officer raised the alarm and did not immediately phone for an ambulance. When another member of staff began work eight minutes later, he called for an ambulance. The paramedics reached Mr Lasinskas' cell at 7.37am, but at 7.45am, they recorded that Mr Lasinskas had died.

Findings

9. Mr Lasinskas was evidently concerned about being repatriated to Lithuania. The Ministry of Justice policy on deporting and repatriating foreign national prisoners recognises their increased vulnerability during the process, and expects prison staff to use suicide and self-harm prevention procedures to support prisoners identified as at risk. Staff at Huntercombe tried to support Mr Lasinskas through the repatriation process and to minimise his risk, but they did not consider that he needed to be supported by suicide and self-harm prevention procedures. We do not think that his behaviour or demeanour was so concerning in the days leading to his death that staff could reasonably have predicted his actions or prevented his death.

10. We are concerned that, contrary to local and national policies, staff did not request an ambulance as soon as the alarm was raised. We also consider that staff need clear guidance about the circumstances in which they are not expected to attempt resuscitation.

Recommendations

- The Governor should ensure that all prison staff understand their responsibilities during medical emergencies and that the control room staff call an ambulance immediately when an emergency code is called.
- The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Huntercombe informing them of the investigation and asking anyone with relevant information to contact her. Three prisoners wrote to Ms MacIvor.

12. The investigator visited HMP Huntercombe on 3 May 2015. She obtained copies of relevant extracts from Mr Lasinskas' prison and medical records and interviewed five prisoners.

13. The investigator interviewed 12 members of staff and five prisoners at HMP Huntercombe in May and June 2016. She interviewed three additional staff members by phone on 6 July.

14. NHS England commissioned a clinical reviewer to review Mr Lasinskas' clinical care at the prison. The clinical reviewer joined the investigator for interviews at the prison in June.

15. We informed HM Coroner for Oxfordshire of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Lasinskas' parents to explain the investigation and to ask if they had any matters they wanted the investigation to consider. The family did not respond.

Background Information

HMP Huntercombe

17. HMP Huntercombe is a low security prison that holds up to 430 adult male foreign national prisoners. Health services are provided by Oxford Health NHS Foundation Trust and nursing staff are available from 7.45am until 6.30pm.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Huntercombe was in January 2013. Inspectors reported that Huntercombe was a good institution that was doing well in adapting to its new role as a foreign national prison. The quality of ACCT documents was mostly good, and while Inspectors recommended that the prison offer counselling services, prisoners were satisfied with the quality of mental health treatment and were involved in the planning of their care. Staff-prisoner relationships were generally good and personal officer work was reasonable.

Independent Monitoring Board

19. 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 December 2014, the IMB reported that Huntercombe was a well-run prison. The IMB noted an improvement in the understanding of and provision for the needs of the foreign national prison population. The IMB was positive about work that had been done to improve understanding and co-operation between the Home Office, and the prison's Safer Custody Team and Offender Management Unit.

Previous deaths at HMP Huntercombe

20. Mr Lasinskas' death is the first self-inflicted death at HMP Huntercombe since the Ombudsman began investigating all deaths in prisons in 2004.

Assessment, Care in Custody and Teamwork

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

The Early Removal Scheme

22. The Early Removal Scheme was introduced in 2004 and applies to foreign national prisoners who are subject to deportation or administrative removal from the UK. Under the scheme, such prisoners can be removed from prison earlier than the half-way point of their sentence, to allow their deportation or removal from the UK.

23. The scheme is mandatory; all determinate sentenced foreign national prisoners who are liable to removal must be considered. Prisoners who are returned to their country of origin under the scheme are released into the community on arrival.

Repatriation

24. Repatriation is the process where a prisoner serving a sentence in one country serves the rest of their sentence in their country of origin. This can only happen where their country of origin has an international agreement in place with the United Kingdom. For repatriation to occur, the Home Office must first issue the prisoner with a deportation order.

25. Repatriation can be compulsory or voluntary. If the Home Office is considering compulsory repatriation, the Cross Border Transfer Unit in the Ministry of Justice will notify the prisoner in writing, and provide information about the process and the prisoner's ability to appeal the decision.

Key Events

26. Mr Darius Lasinskas moved to the United Kingdom from Lithuania in 2010. On 2 March 2015, he was charged with wounding with intent to do grievous bodily harm. As he was being arrested, Mr Lasinskas took a knife from his pocket and stabbed himself in the chest. He was taken to hospital and treated for a partially collapsed left lung and a four-centimetre stab wound. On 5 March, Mr Lasinskas was discharged from hospital, appeared in court and was remanded to HMP Lincoln. He spent a night in police custody and arrived at Lincoln on 6 March. This was his first time in prison. Staff and prisoners who knew Mr Lasinskas told the investigator that Mr Lasinskas spoke good English. No one used an interpreter to communicate with him while he was in prison.

27. On 6 March, a nurse assessed Mr Lasinskas in reception. Mr Lasinskas' Person Escort Record, which accompanied him from police custody to the prison, included a self-harm warning form that noted he had stabbed himself during his arrest, and that he had tried to hang himself two months earlier.

28. The nurse referred Mr Lasinskas to the mental health team and started Prison Service suicide and self-harm prevention procedures, known as ACCT. Mr Lasinskas told her that he had no current thoughts of suicide or self-harm. One week later, staff ended ACCT procedures after Mr Lasinskas said he had no thoughts of suicide or self-harm and that he felt supported, and the actions set to reduce his risk had been completed.

29. On 8 May, Mr Lasinskas was sentenced to four years and six months imprisonment. Later that month, he was transferred to HMP Stocken.

30. On 19 June, the Home Office wrote to Mr Lasinskas to tell him they were considering him for deportation under the Early Removal Scheme. Mr Lasinskas signed a form indicating that, while he understood that he could appeal this decision, he did not want to and was happy to be deported.

31. On 23 June, Mr Lasinskas was transferred to HMP Huntercombe. Two days later, he saw an immigration officer about his deportation. She told Mr Lasinskas that the earliest date that he could be released from prison and deported to Lithuania was 9 September 2016. On 29 June, Mr Lasinskas gave the prison permission to contact the Lithuanian authorities to let them know he was in prison.

32. On 14 July, the immigration officer gave Mr Lasinskas a letter from the Home Office confirming that they planned to deport him. Mr Lasinskas signed a form saying that he did not want to appeal the Home Office's decision, and wanted to leave the United Kingdom as soon as possible.

33. On 24 July, the immigration officer served Mr Lasinskas with his deportation order and explained that, because Mr Lasinskas was being deported, the United Kingdom could transfer him to serve the remainder of his sentence in a Lithuanian prison through the repatriation process. It appears that this was the first time Mr Lasinskas was told about repatriation. She did not record how Mr Lasinskas had responded to the information.

34. On 27 July, Mr Lasinskas' offender supervisor completed an assessment of risk and needs. She noted that, when Mr Lasinskas had stabbed himself, he had wanted to die because he felt regret and remorse about his offence. Mr Lasinskas agreed to be referred to the mental health team to assess his suitability for restorative justice, so he could explain his actions to his victim.

35. On 30 July, a worker from the mental health team assessed Mr Lasinskas. Mr Lasinskas told her that he had received repatriation paperwork. He said that he did not want to go to a Lithuanian prison, was very worried about this and was having trouble sleeping. Mr Lasinskas scored low on anxiety and depression screening tools (indicating that he was not very depressed or anxious) and said that he had no plans to harm himself again. She gave Mr Lasinskas some herbal tea to help him sleep and referred him for relaxation classes. Mr Lasinskas did not attend two relaxation sessions in August, but there is no evidence that anyone asked him why he had not attended.

36. On 13 August, Mr Lasinskas completed a form explaining why he did not want to be repatriated. He wrote that he had witnessed a murder in Lithuania, and the perpetrator was in prison there. He said that his life would be in danger if he was imprisoned in Lithuania. Prisoner A, a friend of Mr Lasinskas', told the investigator that Mr Lasinskas was worried that his family would find out that he had been in prison in the United Kingdom.

37. On 18 September, Mr Lasinskas refused to sign his repatriation paperwork. On 12 October, his offender supervisor spoke to Mr Lasinskas about his concerns about repatriation. She advised him to get legal advice and left details with wing staff about how he could appeal against his repatriation.

38. On 21 October, Mr Lasinskas' lawyer wrote to the Cross Border Transfers Unit, in the Ministry of Justice, explaining why Mr Lasinskas feared being transferred to a Lithuanian prison. On 23 October, the Cross Border Transfers Unit replied, noting that they were seeking information from the Lithuanian authorities and would write again when they received a response.

39. On 17 November, the offender supervisor told Mr Lasinskas that his victim did not want to participate in restorative justice.

40. On 20 January 2016, the Cross Border Transfers Unit wrote again to Mr Lasinskas' lawyer explaining that the Lithuanian authorities had said that they would place Mr Lasinskas in a remand facility on his return to Lithuania, while they decided where he should serve his sentence. The Unit wrote that they would be proceeding with his repatriation. Six days later, they sent a letter to Mr Lasinskas saying that they had passed the transfer request to the Lithuanian authorities.

41. On 24 February, the offender supervisor gave Mr Lasinskas papers confirming that a Lithuanian court had passed a sentence (the sentence length was not specified but the papers noted that Mr Lasinskas would be eligible for conditional release in June 2017). Mr Lasinskas completed a form indicating that he wanted to appeal this sentence. She advised Mr Lasinskas to contact his immigration lawyer. The investigator tried to contact Mr Lasinskas' immigration lawyer but they did not respond. Prison staff told the investigator that, once Mr Lasinskas'

case had been passed to the Lithuanian authorities, they were not informed of the information being sent to him. This meant that they were not able to offer him support in the same way that they had when he received communication from the United Kingdom authorities.

42. On 25 April, Mr Lasinskas stayed in his cell and did not go to his job working in the prison gardens. An officer told investigators that Mr Lasinskas had a good attendance record so, that morning, she asked why he did not want to go to work. Mr Lasinskas said that he had just received news about his repatriation and was quite upset. She told the investigator that she advised Mr Lasinskas to appeal the decision. She said that she got the impression that a friend of Mr Lasinskas was helping him deal with the matter in Lithuania. Mr Lasinskas told her that he just needed a bit of time to get his head around what was going on. She discussed this with the gardens instructor and they agreed not to punish him for missing work (which is supposed to happen under local policy).

43. The next day, 26 April, Mr Lasinskas again refused to go to work. The officer encouraged him to work because she thought it would be better for him to be out of his cell, with other people. She warned Mr Lasinskas that he would lose his job if he refused to go to work. Mr Lasinskas still refused and remained in his cell for the second day.

44. Prisoner A said that some time before his death Mr Lasinskas told him that his appeal against repatriation had been unsuccessful. He said that after this Mr Lasinskas changed. He said that Mr Lasinskas had never talked about suicide, but that after his appeal failed, he said 'all hope is lost'.

45. On 27 April, Mr Lasinskas was removed from garden work, in line with the local policy, because he had refused to attend for two days.

46. At 5.51pm, Mr Lasinskas phoned a Lithuanian friend who lived in the United Kingdom. Mr Lasinskas said he planned to call his solicitor the next day, and said that he would phone his friend again at the same time the next day. That evening Prisoner B spoke to Mr Lasinskas in the queue for dinner. He had no concerns about Mr Lasinskas, who ended the conversation with 'see you tomorrow'. After dinner, Mr Lasinskas played computer games in his cell with Prisoner A until about 6.15pm, when all of the prisoners were locked in their cells for the night. He said that, as he left the cell, Mr Lasinskas hugged him and told him he was a good friend, then said 'see you tomorrow'. He told the investigator that he had no particular concerns about Mr Lasinskas when he left his cell that night.

47. At approximately 8.30pm, the night patrol officer carried out a routine check of all prisoners on the wing. She said that Mr Lasinskas was in bed watching TV. She said she did not notice anything unusual during the night on her walks around the wing.

Thursday 28 April

48. At 6.40am on 28 April, the night patrol officer carried out a routine check of all the prisoners on the wing. She looked through the observation panel in Mr Lasinskas' cell door and noticed that his light was on, which was unusual as he

was normally asleep at that time. She said that she saw Mr Lasinskas' legs in the left corner of the cell and thought he was using the toilet. She did not speak to Mr Lasinskas and carried on with her check.

49. At about 7.10am, Officer A carried out another routine check of all the prisoners on Mr Lasinskas' landing. He saw Mr Lasinskas' legs poking out from under the privacy curtain around the toilet and thought he was in an odd position. He angled his head to get a better look through the observation panel in Mr Lasinskas' cell door and saw that he was on the floor to the left side of the toilet, with his legs stretched out in front of him. He could see blood on Mr Lasinskas' chest, but could not see his face because it was behind the privacy curtain.

50. Officer A was not carrying a radio because the night staff had not yet handed theirs over, so he ran to the wing office and told Officer B and the night patrol officer that there was a code blue emergency (which indicates circumstances such as when a prisoner is unconscious or having difficulty breathing). At 7.15am, Officer B radioed a code blue, but as he did not hear a response, he asked the night patrol officer to radio another code blue, which she did at 7.16am. Officer A, followed by Officer B and the night patrol officer, ran back to Mr Lasinskas' cell.

51. Officer A went into Mr Lasinskas' cell and saw that Mr Lasinskas was sitting underneath his cupboard, with a piece of sheet twisted around his neck and tied to the cupboard. He cut the sheet from around Mr Lasinskas' neck with his anti-ligature knife. He checked Mr Lasinskas for a pulse, but could not find one.

52. Officer B told Officer A that he could leave the cell, as he was clearly shocked. A custodial manager and another officer arrived at Mr Lasinskas' cell very quickly. Officer B told the custodial manager that Mr Lasinskas had died, because he was cold and there were some signs of rigor mortis. The staff decided that they should not try to resuscitate Mr Lasinskas.

53. A physical education instructor also responded to the code blue. The custodial manager told him that Mr Lasinskas had died. However, both men decided to check Mr Lasinskas again for any signs of life. Although Mr Lasinskas' body was stiff and the instructor thought that rigor mortis had set in, he began cardiopulmonary resuscitation. Officer C said the duty governor came into the cell and told him to continue resuscitation. Another officer arrived a few minutes later and helped Officer C with the resuscitation attempt.

54. An officer was alone in the prison control room at 7.15am on 28 April. She said that she was busy letting day staff into the prison when Officer B and then the night patrol officer radioed the code blue emergencies, and she did not call an ambulance immediately. She said staff could only call an ambulance from the phone in the room next to the control room. The officer who had been assisting her in the control room left to respond to the code blue so she did not feel able to leave her post to call an ambulance.

55. At about 7.20am, an officer started his shift in the control room. He asked his colleague if she had called an ambulance, and when she replied that she had not, he went to the room next door and called for one at 7.23am.

56. At 7.34am, the paramedics arrived at the prison and were at Mr Lasinskas' cell at 7.37am. At 7.44am, a second team of paramedics arrived. At 7.45am, a doctor with the paramedics confirmed that Mr Lasinskas had died.

57. After Mr Lasinskas' death, staff found a note in his cell addressed to his friend, saying that he was tired of everything, and that things would have been okay if not for his repatriation and having to serve another three years in prison in Lithuania. He had also circled the date 27 April on the calendar in his cell and had written 'Viso Gezo' underneath, which means 'Good Bye' in Lithuanian.

Contact with Mr Lasinskas' family

58. At 8.15am on 28 April, the family liaison officer and a chaplain phoned Mr Lasinskas' family in Lithuania with the help of an interpreter. The chaplain told Mr Lasinskas' father that Mr Lasinskas had died. Mr Lasinskas' parents did not know that their son was in prison. Mr Lasinskas' father asked about how Mr Lasinskas' body would be returned to Lithuania.

59. Later that morning, the chaplain phoned Mr Lasinskas' friend, again using an interpreter. Mr Lasinskas' friend confirmed that Mr Lasinskas had no family in the United Kingdom. The chaplain offered his support.

60. On 30 April, the chaplain spoke to Mr Lasinskas' father and sister. He offered his condolences and confirmed that the prison would pay for the cost of repatriating Mr Lasinskas' body and his funeral in line with Prison Service instructions.

Support for prisoners and staff

61. After Mr Lasinskas' death, the duty 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.

62. The prison posted notices informing other prisoners of Mr Lasinskas' 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 Lasinskas' death.

Post-mortem report

63. The post-mortem report concluded that Mr Lasinskas died as a result of compression of the neck. The report stated that homemade alcohol ('hooch') was found in Mr Lasinskas' cell after his death. The toxicology report found alcohol in Mr Lasinskas' blood at twice the legal limit for driving. However, the pathologist concluded that alcohol did not play a part in Mr Lasinskas' death. Officers told the investigator that they had never had any concerns or suspicions that Mr Lasinskas was involved in brewing alcohol or consuming it.

Findings

Identification of risk of suicide and self-harm

64. Prison Service Instruction (PSI) 64/2011, which covers safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. Mr Lasinskas had some of the risk factors for suicide including previous suicide attempts, impulsiveness, and feelings of hopelessness about the repatriation process. However, he had been identified as at risk of suicide and self-harm only once, in the first week he was remanded to prison. Staff knew that Mr Lasinskas was worried about his repatriation and did not want to be returned to a Lithuanian prison. However, neither staff nor prisoners who knew Mr Lasinskas had any particular concerns about this vulnerability in the days leading to his death. We do not think that staff could have predicted or prevented his actions on 28 April.

Managing risk during the repatriation process

65. Prison staff told us that it was possible to offer support to prisoners who were being deported because they were kept informed of the process and the paperwork was in English. However, they said it could be harder to identify risk and vulnerability among prisoners once repatriation had been agreed as the authorities in their countries of origin sometimes communicated directly with the prisoner.

66. The Foreign National Offender Policy team in the Ministry of Justice told the investigator that they encouraged the authorities in countries who had signed repatriation agreements to send all paperwork through the Cross Border Transfer Unit, rather than directly to prisoners. This meant that the Unit and prison staff were fully informed about the progress of the repatriation process and could support vulnerable prisoners appropriately. However, they said that sometimes paperwork was sent directly to prisoners, which made managing risk much harder.

67. A manager in the Offender Management Unit at Huntercombe told the investigator that staff had realised that the repatriation process could cause greater concern than deportation, and so they had introduced some new processes to identify and minimise risk. Offender supervisors now hand deliver to prisoners all repatriation and deportation paperwork, so they can explain the contents and ensure prisoners have support if they receive bad news.

68. Since Mr Lasinskas' death, wing officers now carry out a risk assessment with every prisoner who receives immigration documents. If the officer identifies that the prisoner is at risk of suicide or self-harm, they can refer the prisoner to the Safer Prison Team. The risk assessment form prompts the officer to consider whether to begin ACCT procedures or place the prisoner on the prison's risk register (which means the prisoner is discussed at the morning management meeting and staff observe them more closely).

Emergency response

69. Prison Service Instruction (PSI) 03/2013 Medical Emergency Response Codes, contains mandatory instructions that prisons should have a protocol with guidance to staff about efficiently communicating the nature of a medical emergency, and ensuring that there are no delays in calling an ambulance. It states that staff must call an ambulance as soon as a medical emergency is called over the radio network without waiting for further information.

70. Huntercombe's local policy 'Code Red and Code Blue' instructs staff in the control room to immediately request an ambulance when they hear either of those codes. The officer, who was working alone in the control room when the two code blue calls were made, did not immediately call for an ambulance, which meant there was an eight minute delay in an ambulance being requested. She said that she did not call an ambulance because she was alone in the control room at a busy period and she would have had to leave the control room to use the phone in the neighbouring room.

71. Although we do not think that the delay in calling an ambulance affected the outcome for Mr Lasinskas, in other cases, even a short delay can have a significant impact on a person's chance of survival in an emergency. We make the following recommendation:

    The Governor should ensure that all prison staff understand their responsibilities during medical emergencies and that the control room staff call an ambulance immediately when an emergency code is called.

72. The European Resuscitation Council Guidelines 2015 recommend continuing cardiopulmonary resuscitation unless there is clear evidence that any attempt will be futile, such as where there is rigor mortis.

73. All the prison staff involved in the emergency response told investigators that they felt certain that Mr Lasinskas had died and that rigor mortis was present, but some thought they were required to continue resuscitation until someone with medical qualifications told them to stop. It was apparent from interviews with staff that attempting to resuscitate Mr Lasinskas was traumatic for them.

74. We understand staff's commendable wish to continue performing resuscitation until death has been formally confirmed, but do not consider that they should be expected to carry out resuscitation in circumstances when it is clear from the presence of signs such as rigor mortis that the person is dead. Staff need guidance and reassurance about when it is acceptable not to attempt resuscitation, to minimise the distress for all involved. We make the following recommendation:

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

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141