Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Colin Perry, a prisoner at HMP Nottingham on 28 June 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*

© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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 Colin Perry was found hanged in his cell at HMP Nottingham on 28 June 2016. Mr Perry was 33 years old. I offer my condolences to Mr Perry's family and friends.

I am concerned that suicide prevention measures were started twice but lasted for only a day on both occasions, and that neither substance misuse nor healthcare staff were consulted about ending support. I have criticised the approach to suicide prevention at Nottingham in previous investigations and it is very disappointing to have to do so again.

I am also concerned that staff did not effectively manage Mr Perry's suspected use of new psychoactive substances, which is likely to have been contributory factor to his mental state before his death.

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 **March 2017**

Contents

Summary 3
Background Information 6
Key Events 8
Findings 13

Summary

Events

1. On 4 February 2016, Mr Colin Perry was convicted of firearm offences and taken to HMP Nottingham to await sentencing. Mr Perry discussed his drug and alcohol use in reception and was prescribed an alcohol detoxification and methadone maintenance programme. He shared a cell with his brother on the integrated drug treatment wing until April 2016, when his brother was released.

2. There were three occasions that staff suspected Mr Perry was using illegal substances, including new psychoactive substances (NPS), and he was found in possession of a mobile telephone. Although he was receiving support from the substance misuse team, there is no evidence that he discussed his NPS use with them and staff did not always alert security of their suspicions.

3. Mr Perry was sentenced to six years imprisonment on 10 March, but no one reviewed his risk factors despite his change of status. Shortly after he was sentenced, Mr Perry started a methadone detoxification programme. He also began hepatitis C treatment.

4. On 24 May, Mr Perry said he had swallowed razor blades and staff began Prison Service suicide and self-harm prevention procedures (known as ACCT). The ACCT process was closed the next day, without consultation with the healthcare or substance misuse teams. Staff started ACCT monitoring again on 7 June, after Mr Perry cut his arm. Again, officers closed the ACCT the next day without speaking to healthcare or substance misuse colleagues.

5. Mr Perry used a mobile telephone for a distressing call the day before he died. He sent a text to his family late on 27 June to say he was sorry.

6. At 6.18am the next morning, 28 June, an officer saw Mr Perry hanging through the cell door observation panel during a roll check. Officers could not open the cell door and there was a delay while they located anti-barricade equipment. Once staff had managed to open the door, they tried to resuscitate him even though Mr Perry had rigor mortis. Paramedics pronounced Mr Perry's death at 6.41am.

7. A toxicology report found that Mr Perry had NPS in his bloodstream and that this might have contributed to his mental state before he died.

Findings

8. We are concerned about the operation of suicide prevention procedures at Nottingham. Mr Perry self-harmed twice, and, on both occasions, officers ended suicide prevention procedures after only one day, without consultation with the substance misuse team or healthcare staff.

9. We are concerned about the availability of and demand for drugs at Nottingham. Mr Perry was suspected of using new psychoactive substances, but there is no evidence that anyone from the substance misuse team addressed or spoke to him about this or offered him support. There is no evidence that his suspected substance misuse was taken into consideration when assessing his level of risk.

10. We found that there was an unreasonable delay in locating anti-barricade equipment to gain access to Mr Perry's cell, and no one called the appropriate emergency code when officers found him. Although this did not make a difference to Mr Perry, it could to another prisoner in a similar situation. Finally, healthcare staff inappropriately tried to resuscitate Mr Perry when there were signs of rigor mortis.

Recommendations

- The Governor should ensure staff assess and manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular, that:
    - healthcare staff should review prisoners' risks when they have received a change of status;
    - ACCT case reviews should be multidisciplinary, with healthcare representation at all first case reviews; and
    - the assessment of risk takes account of all the prisoners' circumstances and risk factors and not just their personal presentation.
- The Governor should ensure that staff consistently follow a clear pathway for managing prisoners suspected of using NPS and other illegal substances, and that security intelligence information is acted on quickly and investigated where necessary.
- The Governor should ensure that all staff are made aware and understand PSI 3/2013 and their responsibilities during an emergency, and where important equipment is located.
- The 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 Nottingham, informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

12. The investigator visited Nottingham on 5 July 2016. She obtained copies of relevant extracts from Mr Perry's prison and medical records.

13. NHS England commissioned a clinical reviewer to review Mr Perry's clinical care at the prison. The investigator interviewed 15 members of staff and a prisoner at Nottingham on 19 July, 9 and 10 August in person and over the telephone. She carried out joint healthcare interviews with the clinical reviewer.

14. We informed HM Coroner for Nottinghamshire of the investigation who sent the results of the post-mortem and toxicology examinations. We have given the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Perry's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Perry's mother and brother asked what Mr Perry did in the two days before he died. They received a copy of the initial report, but did not make any further comments.

Background Information

HMP Nottingham

16. HMP Nottingham is a local prison serving the courts in Nottinghamshire and Derbyshire and holds over 1,000 men. Nottinghamshire Healthcare Trust provides health services at the prison.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Nottingham was in February 2016. Inspectors found that recommendations from previous Prisons and Probation Ombudsman death in custody reports were being addressed, but some recurring themes required consistent attention and reinforcement. Inspectors noted that the prison did not have a local suicide and self-harm prevention strategy. The quality of suicide prevention documentation was variable and many still had weaknesses, including the quality of case reviews, reviews were often not multidisciplinary, case management was inconsistent, caremaps were often limited and observations were not always completed at the correct frequency and were too predictable. Two thirds of staff told inspectors they had not received safer custody refresher training within three years.

18. Inspectors found that the prison's substance misuse policy was detailed and comprehensive, and included plans for supply and demand reduction. Drug strategy meetings took place regularly and were well attended. Staff held weekly meeting to discuss problems with prisoners using new psychoactive substances. Half of the prisoners surveyed by the Inspectorate reported that it was easy or very easy to get drugs in prison, although inspectors found that work to reduce drug supply seemed to be having an impact.

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 February 2016, the IMB reported that they were concerned about the prevalence of new psychoactive substances and the negative consequences for prisoners' health and wellbeing, and the stability of the prison.

20. The IMB welcomed the prison's efforts to detect mobile telephones, but reported that a significant volume of illicit items continued to get into the prison.

Previous deaths at HMP Nottingham

21. Since 2013, two prisoners have hanged themselves at HMP Nottingham. In a 2013 investigation, we commented on the inadequacy of the suicide monitoring procedures. In that investigation, we found that the case reviews were not multidisciplinary, the prisoner's risk was not considered adequately, and staff did not give the prisoner sufficient support. We found very similar failings in the management of Mr Perry's risk.

Assessment, Care in Custody and Teamwork

22. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce risk and how best to monitor and supervise the prisoner.

23. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent he prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions on the caremap have been completed.

24. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

New psychoactive substances

25. NPS are an increasing problem across the prison and immigration detention estates. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Psychological effects can include psychosis and hallucinations, depression and suicidal thoughts, antisocial or paranoid behaviour and emotional and erratic behaviour.

26. As well as emerging evidence of dangers to both physical and mental health, there are other links to suicide or self-harm. Trading in these substances, while in custodial settings, can lead to debt, violence and intimidation.

27. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with use of NPS. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies because of the links between NPS and debt and bullying.

Key Events

28. Mr Colin Perry was convicted of firearm offences on 4 February 2016 and taken to HMP Nottingham to wait for sentencing. This was not his first time in prison. An accompanying Person Escort Record (PER, a record that accompanies a prisoner from court to the prison) noted that he had epilepsy and that he was a risk to others because of his offence.

29. A nurse saw Mr Perry on reception. His urine tested positive for opiates and cannabis. He said he had been prescribed methadone (an opiate substitute) in the community, used new psychoactive substances (NPS), drank a large amount of alcohol daily, and said he had epilepsy. Mr Perry saw a prison GP next. He told the doctor he had hepatitis C, epilepsy and was opiate-dependent. The GP prescribed Mr Perry an alcohol detoxification programme and a low dose of methadone until his GP confirmed his community prescription.

30. Mr Perry was given a cell on the induction wing which he shared with his brother. Later that morning the prison confirmed with Mr Perry's doctor that he received 40ml of methadone daily in the community, and a prison GP amended his prescription. The GP also prescribed Mr Perry medication for epilepsy.

31. On 6 February, Mr Perry discussed his substance misuse with a senior substance misuse practitioner and agreed he would remain on a maintenance programme until he was sentenced. During a substance misuse assessment on 9 February, Mr Perry told a nurse that he knew he would start a methadone reduction programme once he was sentenced, but he wanted to remain on the maintenance programme until then. She discussed Mr Perry's epilepsy and referred him for hepatitis C treatment.

32. Mr Perry and his brother moved to a cell on the substance misuse wing on 11 February and started working in the sewing workshop.

33. On 7 March, Mr Perry told the senior substance misuse practitioner that he wanted to stay on a methadone maintenance programme rather than reduce the dose. The practitioner agreed to this until Mr Perry was sentenced.

34. On 9 March, Mr Perry had a seizure. Healthcare staff were called to his cell and officers asked for an ambulance. Mr Perry regained consciousness before the ambulance arrived, and paramedics checked his observations (all of which they recorded as satisfactory). Later that day, officers found Mr Perry with a mobile telephone and took him to the segregation unit, where a nurse assessed Mr Perry to be fit to stay there. He returned to his cell the next day.

35. On 10 March, Mr Perry appeared in court via video link and was sentenced to six years in prison. There is no record of Mr Perry being formally assessed by healthcare staff after he was sentenced, which is required under national instructions.

36. Mr Perry's brother was released from prison on 8 April. Mr Perry remained in a cell on his own for the rest of his time in prison.

37. On 26 April, during a routine search, staff found sewing needles, a pen pipe and a USB cable in Mr Perry's single cell. As a result, staff put Mr Perry on basic regime (this meant that his television, among other items, was removed until 17 May, when they were returned). Staff submitted a security intelligence report and noted that Mr Perry was already receiving support from the substance misuse team.

38. On 10 May, a nurse noted in Mr Perry's medical records that she suspected he was taking new psychoactive substances (NPS). She said she submitted a security report, but there was no record of this. She recorded that he was already working with the substance misuse team.

39. On 11 May, the senior substance misuse practitioner told Mr Perry that he needed to start a methadone detoxification programme, as he had been sentenced. Mr Perry was reluctant, but he explained that if they could not agree on a detoxification programme, he would be put on a standard 12-week detoxification plan. There is no record that they discussed his suspected NPS use from the previous day. They agreed to talk again on 16 May, when Mr Perry agreed to reduce his methadone dose from 40ml to 35ml, but would not commit to a full plan. He explained again that he would prefer to manage Mr Perry's detoxification collaboratively, but he was prepared to impose a programme without his agreement. Mr Perry's dose was reduced to 35ml the next day.

40. On 24 May, Mr Perry told officers that he had swallowed about 20 razor blades. A nurse examined him. She found there was no significant trauma to his mouth or throat, so she advised him to eat bread and alert staff if he felt unwell. She did not consider it necessary for Mr Perry to go to hospital or to ask for staff to monitor him.

41. A Supervising Officer (SO) started suicide and self-harm prevention measures, known as ACCT. He recorded that Mr Perry had swallowed razor blades because telephone numbers had not yet been added to pinphone account, apparently for security reasons. The SO arranged for his sister's telephone number to be added to his account and asked staff to check him hourly until he had been fully assessed.

42. The next morning, an officer assessed Mr Perry as part of ACCT procedures. The SO and the officer held a first case review with Mr Perry later that afternoon. No one from the substance misuse team or the healthcare team attended. Mr Perry told the officers that his telephone issues had been resolved and he had no thoughts of suicide or self-harm. He said he had no physical symptoms after swallowing razor blades. The SO agreed that Mr Perry was at low risk of suicide or self-harm, and closed the ACCT.

43. On 26 May, a nurse explained that Mr Perry's hepatitis C treatment had possible side effects, including feeling low in mood. Mr Perry wanted to start the treatment, so she arranged for him to have blood tests. (He started his treatment on 16 June.)

44. On 1 June, Mr Perry met the senior substance misuse practitioner and reluctantly agreed to follow a methadone detoxification plan, reducing from 35mls, by three mls every seven days, to start on 6 June. Also on 1 June, a SO held an ACCT

post closure review with Mr Perry. He did not speak to healthcare colleagues or the substance misuse team, but noted that the ACCT should remain closed.

45. The senior substance misuse practitioner saw Mr Perry again on 7 June, and noticed that he had some cuts on his left arm. Mr Perry told him that he was upset because his grandmother was unwell. The practitioner started ACCT monitoring, requesting that officers observe Mr Perry hourly. An officer arranged for Mr Perry to speak to his family.

46. During an ACCT assessment interview the next day, Mr Perry told an officer that his grandmother had died and he cut himself because he was frustrated that he could not contact his family, although he had since spoken to them. (Mr Perry's family have since told us that his grandmother had not died and they did not speak to him at this time.) Mr Perry told the officer that he had no other issues, did not feel he needed any further support and would speak to officers if any other problems arose. At a case review that afternoon, two officers agreed that Mr Perry's risk was low because he had now spoken to his family and agreed to close the ACCT. They did not speak to the healthcare team or substance misuse colleagues. On 15 June, an officer held a post closure review with Mr Perry and agreed that the ACCT should remain closed.

47. On 18 June, Mr Perry told staff he had had a seizure in his cell. A nurse examined him. Mr Perry told her that he had been taking his prescribed medication, but had recently felt stressed following his grandmother's death. She advised him to rest and referred him for a review at the epilepsy clinic.

48. At a complex care meeting on 21 June, a nurse said that Mr Perry was not coping well with his hepatitis C treatment and had trouble sleeping. Mr Perry said he wanted to stop the treatment and she arranged for him to see another nurse to discuss this. Mr Perry saw the nurse on 23 June. He told her that he had struggled with the treatment at first as he had had insomnia, but things had improved and he wanted to continue.

49. On 24 June, Mr Perry telephoned his ex-partner. Mr Perry spoke about a problem he was having with his teeth and swollen gums, but was laughing and seemed okay. He said he had spoken to the Governor about moving to a different prison. Although there is no record of this conversation, the Governor remembered that Mr Perry wanted to move nearer to his family when he transferred to another prison, and he seemed in good spirits.

50. On 25 June, Mr Perry told a nurse at the medication hatch on the wing, that he had had a seizure during the night. He said he was in a single cell, so nobody was with him. She said she would discuss this with officers (she did not do so before Mr Perry died), as he should not be in a cell on his own because he was epileptic.

51. Mr Perry attended a Mormon worship group on 27 June, held by a chaplain. He had previously told them that his grandmother had died and that he had submitted an application to attend her funeral, but this had been denied. (There is no record that Mr Perry submitted an application.) The chaplain said he was not concerned about Mr Perry during worship on 27 June, or when he saw him on the wing later that afternoon and they had a brief conversation.

52. Mr Perry telephoned his girlfriend twice that day, but she did not answer. A prisoner said that Mr Perry had seemed very depressed that day. Mr Perry told him that his relationship had ended and he was upset that he would not see his children. The prisoner did not tell staff and there is no record that Mr Perry spoke to officers. He said he last spoke to Mr Perry as he walked past his cell before they were locked up for the night. He said Mr Perry usually gave him the previous day's newspaper, but he gave him that day's newspaper. He could see Mr Perry was upset and looked as if he had been crying, so suggested they speak in the morning. Mr Perry agreed.

53. An operational support grade (OSG) carried out his first roll check at about 6.00pm that evening. He remembered seeing Mr Perry sitting on his bed when he looked through his cell door observation panel. He was not worried about Mr Perry.

54. After his death, the prison discovered that Mr Perry used an illicit mobile telephone for a distressing call with his girlfriend the day before he died. At 11.38pm, Mr Perry sent a text to his family, from the mobile telephone saying, "Love you all, sorry". Nobody contacted the prison about this.

55. At 6.18am on 28 June, the OSG was counting prisoners and CCTV shows him looking through Mr Perry's observation panel. He said he could not see Mr Perry at first, but then noticed he was close to the door. He did not radio an emergency code or go into the cell, but radioed for the night manager's assistance at 6.20am. The manager arrived at the cell less than a minute later with an officer. They tried to open the door, but Mr Perry's weight was blocking it. The OSG radioed for healthcare assistance and the manager asked someone to collect an anti-barricade tool so they could unscrew the door. There was a delay in finding the equipment and, in the meantime, more healthcare staff arrived. A nurse arrived at 6.21am and asked for an ambulance, so the control room called one without delay.

56. Staff brought the anti-barricade equipment to the cell at 6.31am, and opened the cell door two minutes later. Staff laid Mr Perry on the landing floor, just outside the cell. Nurses immediately began cardiopulmonary resuscitation (CPR). They attached a defibrillator, which recommended that no shock was required. The paramedics arrived on the landing five minutes later and took over CPR. Paramedics pronounced Mr Perry dead at 6.41am.

57. Mr Perry left letters to his girlfriend and children in his cell saying goodbye and that he was sorry.

58. On 4 July, staff received information from a former prisoner that Mr Perry had smoked 'Spice' (an NPS) before he died and this had made him feel suicidal. Police found a mobile telephone in Mr Perry's cell after he died.

Contact with Mr Perry's family

59. The deputy governor and the prison's family liaison officer visited Mr Perry's mother at 10.00am and broke the news of his death. The prison contributed to the cost of Mr Perry's funeral, in line with national instructions.

Support for prisoners and staff

60. After Mr Perry's death, a prison manager 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.

61. The prison posted notices informing other prisoners of Mr Perry's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Perry's death.

Post-mortem report

62. Mr Perry's post-mortem concluded that he died from hanging. Toxicological investigations detected a combination of Mr Perry's prescribed medication as well as synthetic cannabinoids (New Psychoactive Substance) and concluded that this would have affected his judgement in the hours before he died.

Findings

Managing Mr Perry's risk of suicide and self-harm

63. Prison Service Instruction (PSI) 64/2011, covering safer custody, recognises a change in status as a factor that could increase a prisoner's risk of suicide or self-harm. Prison Service Order (PSO) 3050, requires that a protocol is in place to screen prisoners passing through reception for any potential healthcare, suicide or self-harm issues. No one from the healthcare team reviewed Mr Perry after he was sentenced on 10 March.

64. When Mr Perry said he had swallowed 20 razor blades on 24 May, he was correctly identified as at risk of suicide or self-harm, but the supervising officer closed ACCT monitoring procedures the next day. On 7 June, Mr Perry cut his arms, he told staff, because he had been told his grandmother had died. Again, officers stopped ACCT monitoring after one day. On neither occasion did officers speak to the healthcare or the substance misuse teams.

65. We do not feel that staff placed sufficient weight on Mr Perry's self-harm when he said he had swallowed razor blades and cut his arms, or that his level of risk was considered adequately. Officers accepted Mr Perry's explanation about why he self-harmed. Mr Perry was undergoing treatment for hepatitis C, which might have affected his mood. He was epileptic, so should have been sharing a cell. Finally, Mr Perry was unhappy about his methadone detoxification and was suspected of using NPS. All of these factors might have contributed to Mr Perry's level of risk, but none were taken into account because the ACCT was not multidisciplinary.

66. We have criticised Nottingham's suicide and self-harm prevention measures before and we note HMIP's finding that Nottingham does not have a local suicide and self-harm prevention. It is concerning that evidence of indicators of risk did not give rise to effective risk management. We make the following recommendation:

The Governor should ensure staff assess and manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular,

- **healthcare staff should review prisoners' risks when they have received a change of status; and**
- **ACCT case reviews should be multidisciplinary, with healthcare representation at all first case reviews;**
- **the assessment of risk takes account of all the prisoners' circumstances and risk factors and not just their personal presentation.**

Substance misuse

67. The clinical reviewer concluded that Mr Perry's alcohol and drug detoxification were appropriately managed and that he received good support while undergoing clinical treatment for his withdrawal from alcohol and opiates.

68. Mr Perry's friend told the investigator that he had seen Mr Perry smoke NPS while he was in prison, but he had not told staff. On one occasion, drug paraphernalia was found in Mr Perry's cell. On 10 May, a nurse suspected that Mr Perry had taken NPS. Although she recorded this in his medical record, there is no record that the nurse submitted a security incident report. The nurse noted that Mr Perry was already receiving support from the substance misuse team, but there is no evidence that they spoke to him about his NPS use.

69. The nurse should have notified the security department as soon as she had any concerns that Mr Perry was under the influence of an illicit substance. The substance misuse team should have spoken to Mr Perry about his suspected use of NPS. We agree with the Inspectorate that Nottingham's drug strategy is comprehensive and clearly requires staff to follow up suspected drugs use. However, in Mr Perry's case, the strategy was not followed and opportunities were missed to tackle his suspected NPS use.

70. The toxicology report said that Mr Perry had NPS in his system and that it was likely to have affected his state of mind before he died. In July 2015, we issued a Learning Lessons Bulletin about the use of NPS, including the dangers to both physical and mental health and the possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS.

71. We consider it is important that the prison does all it can to eradicate the use of new psychoactive substances and that staff understand how to respond when prisoners appear to be under the influence of such substances. We make the following recommendation:

    The Governor should ensure that staff consistently follow a clear pathway for managing prisoners suspected of using NPS and other illegal substances, and that security intelligence information is acted on quickly and investigated where necessary.

Emergency response

72. The OSG did not radio an emergency code when he discovered Mr Perry. He told investigators that he knew he should have done so, but panicked. As he did not use a radio code, healthcare staff did not know what type of incident they were responding to, and an ambulance was not automatically requested. We understand that staff in this situation are often in shock and do not always remember to follow the correct procedures. However, the Governor should remind staff of what to do in an emergency.

73. It took staff 11 minutes to find the anti-barricade equipment to open Mr Perry's door. Although it clearly would not have made a difference in Mr Perry's case, staff should know where the equipment is kept and be able to collect it immediately. We make the following recommendation:

The Governor should ensure that all staff are made aware and understand PSI 3/2013 and their responsibilities during an emergency, and where important equipment is located.

Resuscitation

74. Once staff had managed to get into Mr Perry's cell, it was apparent he had been dead for some time, as rigor mortis was present. Despite this, healthcare staff attempted to resuscitate him before paramedics pronounced him dead. We consider that it was not necessary to attempt to resuscitate Mr Perry.

75. European Resuscitation Council Guidelines 2010 say "Resuscitation is inappropriate and should not be provided where 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 make the following recommendation:

    The Head of Healthcare should give clear guidance to staff 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