Prisons & Probation
Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Adkhamjon Tovasharov a prisoner at HMP Belmarsh on 30 December 2016

**A report by the Prisons and Probation Ombudsman**
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## Our Vision

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

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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 Adkhamjon Tovasharov died at HMP Belmarsh on 30 December 2016. He was 34 years old. I offer my condolences to Mr Tovasharov's family and friends.

Mr Tovasharov was on remand for the murder of his wife. There is a close association between the murder of a family member and risk of suicide. Overall, I consider Mr Tovasharov received very good care at Belmarsh. He made a determined attempt to kill himself and it would have been extremely difficult for staff to have prevented his death. Nevertheless, in hindsight, I consider that staff relied too much on his presentation rather than his significant underlying risk factors for suicide when assessing his risk. As a result, I am not satisfied that Mr Tovasharov's level of risk was correctly assessed or that the level of observations adequately reflected his level of risk.

Although the officer who found Mr Tovasharov radioed a code blue emergency, the control room did not immediately call an ambulance, as should have happened. I cannot say the delay affected the outcome for Mr Tovasharov but it is disappointing that we have identified a similar failing in four previous self-inflicted deaths at Belmarsh between April 2013 and July 2015.

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** **July 2017**

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# Summary

## Events

1. Mr Adkhamjon Tovasharov was born in Uzbekistan and moved to the UK with his wife in 2007. Their two daughters remained in Uzbekistan with relatives. A third daughter was born in 2015 and lived with her parents in the UK. Mr Tovasharov does not appear to have had a criminal record or any history of mental illness, attempted suicide or self-harm.

2. On 12 December 2016, police found Mr Tovasharov's wife dead at their home. Mr Tovasharov, who was also at home, had cut his wrists and taken several paracetamol tablets with alcohol. Mr Tovasharov was taken to hospital and kept under constant supervision in police custody.

3. On 16 December, Mr Tovasharov was remanded to HMP Belmarsh. Staff began prison service suicide and self-harm monitoring procedures, known as ACCT. Mr Tovasharov was placed under constant supervision in the prison's inpatient unit. Initially, Mr Tovasharov appeared confused and agitated. He said he had no recollection of the events leading to his imprisonment and asked repeatedly to see his wife and to go home.

4. On 19 December, the prison psychiatrist told Mr Tovasharov that his wife was dead and he had been charged with killing her. The psychiatrist assessed Mr Tovasharov's mental health and could not find any sign of mental illness. The same day his risk of suicide was assessed as having reduced from high to raised.

5. Mr Tovasharov continued to be monitored under ACCT procedures on the inpatient unit. On 20 December, he was taken off constant supervision. He was reviewed daily until 23 December and his level of observation was reduced on successive days from every 15 minutes, to every 30 minutes, to hourly, to three times during the day and five times at night. He was moved to a 'safer' cell (a cell with reduced ligature points). On 23 December, staff assessed him as presenting a low risk of suicide.

6. On 24, 25 and 26 December, Mr Tovasharov came out of his cell to socialise with other prisoners and attended some therapeutic group work on 28 December. On 29 December, he said he was still finding it hard to come to terms with what had happened and did not know how to tell his family where he was and why.

7. At about 2.20am on 30 December, Mr Tovasharov was found hanging by a sheet attached to his cell door. He had barricaded the door with his mattress and a chair, tied his hands and feet and filled his mouth with a plastic bag containing tea bags, sugar sachets and milk cartons. Staff and paramedics tried to resuscitate him but he was pronounced dead at 3.24am.

8. After his death, officers found several letters from Mr Tovasharov to his family.

## Findings

9. Mr Tovasharov had several risk factors which indicated he was at high risk of suicide and self-harm. He was charged with murdering his wife, he had recently attempted suicide and it was his first time in prison. Suicide and self-harm monitoring was begun appropriately and Mr Tovasharov spent the first few days at Belmarsh under constant supervision. Constant supervision, which should be used only in periods of crisis, was stopped appropriately after a full mental health assessment and with the approval of the prison psychiatrist.

10. With hindsight, we consider the level of observations was reduced too rapidly after constant supervision was stopped. Mr Tovasharov made a determined attempt to kill himself and we cannot say that more frequent observations would have prevented his death. However, the nature of his risk factors indicated a high risk of suicide and these risk factors were unlikely to diminish in the short term. When considering his risk of suicide and self-harm, there was too much reliance on his behaviour and what he said, rather than an objective evaluation of all risk factors.

11. The night patrol officer radioed a code blue emergency to indicate a prisoner with breathing difficulties but the control room did not call an ambulance immediately as required by national instructions.

## Recommendations

- The Governor and Head of Healthcare should ensure that staff make a considered, objective evaluation of all risk factors when assessing the risk of suicide and self-harm and setting the level of observations.
- The Governor should ensure that the communications room calls an ambulance immediately when a code blue or code red emergency is called.

# The Investigation Process

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

13. The investigator visited Belmarsh on 23 January 2017. She obtained copies of relevant extracts from Mr Tovasharov's prison and medical records. She listened to the emergency radio message from 30 December.

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

15. The investigator and the clinical reviewer interviewed four members of staff at Belmarsh in February 2017. The investigator spoke to another member of staff by telephone.

16. We informed HM Coroner for Southwark of the investigation, who sent us copies of the post-mortem and toxicology reports. We have sent the coroner a copy of this report.

17. One of the Ombudsman's family liaison officers contacted Mr Tovasharov's brother, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Tovasharov's brother asked whether Mr Tovasharov had talked to healthcare staff about what was troubling him and for as much information as possible about his brother's time in prison. We have sent him a copy of this report.

# Background Information

### HMP Belmarsh

18. HMP Belmarsh is a high security and local prison serving the courts of South East London and South West Essex. It holds about 900 men. Oxleas NHS Foundation Trust provides healthcare services. There is 24-hour healthcare cover and a 32-bed inpatient unit.

### HM Inspectorate of Prisons

19. The most recent inspection of HMP Belmarsh was in February 2015 shortly before healthcare services transferred to Oxleas. Inspectors reported that primary mental health services and toilet and shower facilities in the inpatient unit required improvement. Most nursing staff provided good care and interacted well with patients. The safer custody team was impressive and well-motivated. Care for prisoners managed under ACCT procedures was reasonable and most reviews were multi-disciplinary. Prisoners on ACCT felt supported.

### 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 June 2016, the IMB reported that its greatest concern was whether the prison was adequately staffed and the low morale of officers. Frequent changes to the regime were mainly due to staff shortages and resulted in reduced access for prisoners to showers, telephone calls, social time and planned activities.

21. The IMB noted several improvements to healthcare services since Oxleas took over in April 2015. In particular, access to psychological therapy and secondary mental health services had increased.

### Previous deaths at HMP Belmarsh

22. Mr Tovasharov's death was the first self-inflicted death at Belmarsh since July 2015. Our investigation into that death and three previous self-inflicted deaths going back to April 2013, found that the control room did not call an ambulance immediately in response to an emergency code. We repeat our previous recommendations about this in this report.

### ACCT

23. ACCT is the Prison Service care-planning system used 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 the risk and how best to monitor and supervise the prisoner.

24. 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 the prisoner anticipating when they will occur. There should be regular multi-disciplinary 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 of the caremap have been completed.

25. 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.

## Key Events

26. Mr Adkhamjon Tovasharov was born in Uzbekistan and moved to the UK with his wife in 2007. Their two daughters remained in Uzbekistan with relatives. A third daughter was born in 2015 and lived with her parents in the UK. Mr Tovasharov does not appear to have had a criminal record or any history of mental illness, attempted suicide or self-harm.

27. On 12 December 2016, police found Mr Tovasharov at home lying on the bed next to his wife's dead body. He had cut his wrists and taken several paracetamol tablets with alcohol. They arrested him on suspicion of causing his wife's death and took him to hospital.

28. On 13 December, police asked a consultant forensic psychiatrist to assess Mr Tovasharov at the hospital. He said Mr Tovasharov was mute with a fixed stare. He communicated by writing in English. He appeared confused and asked to contact his wife and daughters. He concluded Mr Tovasharov was suffering an acute stress reaction to the recent events and it was not possible to tell at that stage whether he had any underlying mental illness. He said Mr Tovasharov should be placed on suicide watch in police custody. He was taken to a police station and kept under constant supervision.

29. On 14 December, Mr Tovasharov had surgery at hospital to assess the damage to his wrists. The police provided a Russian interpreter but Mr Tovasharov communicated with the doctors by reading and writing English. He repeatedly asked for his wife and daughters and when he was going home. Mr Tovasharov returned to the police station after surgery, where he remained on constant supervision.

30. On 16 December, Mr Tovasharov was remanded to HMP Belmarsh. Mr Tovasharov's escort record, which accompanied him from court to the prison, showed that he was charged with murder and had made a cut to his arm.

31. At an initial health assessment, Mr Tovasharov told a nurse that he had no previous history of mental illness and was physically well. The nurse noted that Mr Tovasharov was not communicating well and appeared confused.

32. A locum GP examined Mr Tovasharov shortly afterwards. He said Mr Tovasharov appeared thought disordered and queried whether he might be hearing voices. Mr Tovasharov said he wanted to go home to his wife and baby and said he had injured his wrists in a road traffic accident. The GP prescribed antibiotics and painkillers. Reception officers began Prison Service suicide and self-harm monitoring procedures, known as ACCT. The GP agreed Mr Tovasharov should be placed on constant supervision in a cell on the inpatient unit.

33. A nurse spoke to Mr Tovasharov when he arrived in the inpatient unit at about 9.00pm. Mr Tovasharov did not respond to her questions and appeared confused and disoriented. He told her his injuries were from a car accident and asked to see his wife.

34. On 17 December, Mr Tovasharov told a nurse during his ACCT assessment that he had three daughters, two of whom lived in Uzbekistan. He said it was stressful being apart from two of his children and he and his wife had argued about the difficulty of bringing their two eldest daughters to the UK. Mr Tovasharov said his wife had left him in September 2016 but towards the end of November they decided to try to make the relationship work again. Mr Tovasharov remembered going to work on 12 December and eating dinner with his wife but the next thing he remembered was waking up in hospital. He could not recall how he had hurt his wrists or why he had ended up in prison and asked if his wife and family knew he was there.

35. The nurse attended the first case review after the assessment with the duty governor and Mr Tovasharov. Mr Tovasharov continued to appear very confused and agitated. He repeated that he wanted to speak to his wife. Mr Tovasharov was assessed at high risk of suicide and self-harm. Three actions were added to the caremap: support from the mental health team, support from the Imam and association time (when prisoners are let out of their cells to socialise with each other).

36. The duty governor held another ACCT review the next day on 18 December, with Mr Tovasharov and the inpatient unit manager. Mr Tovasharov said he remembered the first review but was still unsure of what had happened in the last week. He said he could not believe that he had self-harmed because he had a big family who relied on him and his wife for money. Mr Tovasharov was judged to remain at high risk of suicide and self-harm. Another action was added to the caremap – to get his mobile phone from reception so that he could have some family contact (subject to agreement with the public protection department).

37. On 19 December, Mr Tovasharov attended a third ACCT review with the duty governor, the consultant forensic psychiatrist and a healthcare assistant. The psychiatrist said she combined a full Mental Health Act assessment of Mr Tovasharov with his ACCT review. She said Mr Tovasharov was fluent in English and said he did not need an interpreter when she offered him one. He was bright and educated and she was satisfied he was able to give a full history. Mr Tovasharov told her the main stress in his life had been the difficulty in bringing his two eldest daughters to the UK. This had affected his relationship with his wife. She completed a mini-mental state test (a 30 point questionnaire that measures cognitive impairment), in which Mr Tovasharov scored 30 out of 30 (showing completely normal cognition). She said she could not identify any organic mental illness and Mr Tovasharov did not appear depressed, although he obviously found his situation very stressful.

38. Mr Tovasharov kept asking to see his wife. The psychiatrist told Mr Tovasharov his wife was dead and the police had charged him with killing her. Mr Tovasharov said he did not believe her and wanted to talk to his solicitor. His risk of suicide and self-harm was assessed as reduced from high to raised. Two actions were added to the caremap: for the healthcare manager to get numbers from Mr Tovasharov's mobile phone for family contact and for her to identify his solicitor so he could make contact.

39. The next day, on 20 December, Mr Tovasharov appeared at court via video link and was remanded in custody pending another hearing on 20 February 2017. The same day, he attended an ACCT review combined with the weekly ward round with the inpatient unit manager, a nurse, the complex case manager, the psychiatrist and a junior psychiatrist. The inpatient unit manager had taken over as the ACCT case manager. Mr Tovasharov said he had found the video link stressful. He said his youngest daughter had been placed with foster parents. He had responsibilities to his children and was trying to cope with the news about his wife. The review team decided Mr Tovasharov was still at raised risk of suicide and self-harm but to stop constant supervision and observe him every 15 minutes.

40. On 21 December, Mr Tovasharov attended another ACCT review with the inpatient unit manager, a SO and a nurse. He said he had asked his solicitor some questions about his offence and for numbers from his mobile phone during his video link. The manager said they would contact reception to see if he had brought his mobile in with him. The review team decided Mr Tovasharov was still at raised risk of suicide and self-harm but reduced his observations to once every 30 minutes.

41. On 22 December, the inpatient unit manager and a SO reviewed Mr Tovasharov again. He said he was fine and was trying to come to terms with the fact he would never see his wife again. He repeated that he had responsibilities to his daughters and was not considering suicide. Mr Tovasharov said he found reading helpful because it distracted him and made him less anxious. His observations were reduced to hourly although his risk of suicide and self-harm remained raised. A nurse created a care plan to manage Mr Tovasharov's stress and risk of suicide/self-harm. The plan consisted of:

- multi-disciplinary review of his management and medication;
- ACCT monitoring;
- 1:1 counselling with a nurse;
- monitoring Mr Tovasharov's vital signs and food and fluid intake;
- referral to the complex case team.

42. On 23 December, a prison GP prescribed certirizine and paracetamol for a rash on Mr Tovasharov's arms and abdominal pain. Mr Tovasharov attended a video link hearing and spoke to his solicitor. A planned video link with the family court did not take place after the court failed to link up with the prison.

43. The inpatient unit manager and a SO held an ACCT review with Mr Tovasharov the same day. He said he had received good news from social services about his youngest daughter, who was doing well, and that his wife's parents would be visiting the UK soon to take her back to Uzbekistan. He reassured the manager and the SO that he was focussing on his family and did not feel suicidal. The manager and the SO decided Mr Tovasharov was now at low risk of suicide and self-harm. They reduced his observations to three during the day plus one recorded conversation and five observations over night. Mr Tovasharov said he

was remaining strong for his children. He said his solicitor was working on retrieving his contact telephone numbers because his mobile phone was with the police.

44. On 24 December, Mr Tovasharov complained again of stomach pain and a nurse gave him an antacid. He came out of his cell for association time and appeared to mix well with other prisoners. On 25 and 26 December, he was noted to be calm, polite and sleeping well. He went out for exercise and association both days and spoke to staff and prisoners.

45. On 27 December, Mr Tovasharov told a nurse that he was still trying to understand why he was in prison. He understood the nature of the charge against him but was unable to comprehend how it could have happened. He said his solicitor was going to visit him on 4 January.

46. On 28 December, Mr Tovasharov had a 1:1 session with the nurse who ran therapeutic group activities. She was on long term sick leave at the time of the investigation and has not been interviewed. She recorded that Mr Tovasharov appeared calm and pleasant, alert and coherent. He said, "you know my situation is not easy for me". He collected some new books to read in his cell.

47. Mr Tovasharov attended an ACCT review the same day with the inpatient unit manager, a SO and a nurse. He denied feeling suicidal and said he had to remain strong for his children. He said he was coming to terms with his loss and confirmed his solicitor was trying to get access to his mobile phone for him. He was deemed to be at low risk of suicide and self-harm and his observations remained the same.

48. On 29 December, Mr Tovasharov attended therapeutic group activity but left early because he was feeling tired. He told a nurse that he still found it hard to comprehend that he was in prison. He was not sure how to explain to his family that he was in prison as he had never been in trouble before. The nurse raised the possibility of Mr Tovasharov moving to a bed on the ward (there are two six bedded wards in the inpatient unit) and eventually to a cell on one of the house blocks. Mr Tovasharov said he was not keen on being with other prisoners and having less privacy. They discussed some activities Mr Tovasharov could do in the future when he moved to a wing in the main prison. Mr Tovasharov said he wanted to attend Muslim prayers the next day.

49. An Operational Support Grade (SOG) spoke to Mr Tovasharov at about 7.30pm when she came on duty. He told her he had not had a bad day and thanked her for giving him a flask of hot water. She checked Mr Tovasharov again at 9.52pm and he was watching television. She said Mr Tovasharov had just begun to speak to her that week and appeared to be in a better frame of mind than when he first arrived at Belmarsh. She said at first he had not been talkative and had cried out for his wife.

50. A nurse said he spoke to Mr Tovasharov when he was watching television and he asked for an antacid for indigestion which he gave him. He said Mr Tovasharov appeared in a good mood but was not noticeably different to how he had behaved in the previous few days.

### 30 December 2016

51. The OSG checked Mr Tovasharov at five minutes past midnight and he appeared to be asleep. When she returned to check him again at about 2.20am, she could not see through the observation panel. She said she realised Mr Tovasharov was leaning up against the door and blocking the view. She called his name but he did not reply. A nurse was close by and she called him over.

52. The nurse said he called Mr Tovasharov and then pushed him but got no response. He put his arm through the observation panel and felt between Mr Tovasharov's body and the door. Mr Tovasharov felt warm. He said he worked his hand up to Mr Tovasharov's neck and felt a ligature. He took out his cut down tool and the OSG radioed a code blue emergency. The control room log records the code blue at 2.23am. He cut the ligature, which was made from his sheet, and they heard Mr Tovasharov fall to the floor.

53. The OSG said as soon as she saw the nurse reach for his cut down tool she radioed a code blue and began to open the sealed pouch containing her cell key. The emergency response nurse arrived quickly from the floor below. A custodial manager and two night orderly officers arrived as she opened her sealed pouch and opened the cell door with her key. Mr Tovasharov's body was against the door and he had also rolled his mattress up and wedged a chair between that and his bed to obstruct entry. The custodial manager managed to force the door open enough to kick away the barricade and enter the cell.

54. Mr Tovasharov had tied his hands together in front of him and his feet together, with other pieces of his sheet. Both officers removed the sheets and the emergency response nurse began cardio-pulmonary resuscitation. The custodial manager checked Mr Tovasharov's airway and found he had blocked it with his tea pack including teabags, sugar sachets and milk cartons. The nurse collected a bag of emergency equipment and the OSG collected the automatic defibrillator (a life saving device that gives the heart an electric shock in some cases of cardiac arrest). The custodial manager asked the OSG to radio the control room to call an ambulance. The control room log records this at 2.27am and the London Ambulance Service patient report form records it as 2.26am.

55. The custodial manager managed to remove enough of the items in Mr Tovasharov's mouth to partially unblock his airway. The nurse and the night officers took it in turn to perform chest compressions and give Mr Tovasharov air using an ambu-bag. An officer attached the defibrillator. The nurse said the defibrillator advised giving Mr Tovasharov an electric shock twice.

56. According to their records ambulance paramedics arrived at 2.38am and took over. A second team arrived at 2.50am. They continued life support but pronounced Mr Tovasharov dead at 3.24am.

57. Several letters written by Mr Tovasharov to his family dated 22 and 29 December were found in his cell. They very clearly indicate he was feeling suicidal.

### Contact with Mr Tovasharov's family

58. The deputy governor was appointed family liaison officer. Initial contact was made with the Uzbekistan Embassy because Mr Tovasharov had no relatives in the UK and the prison had no contact details for them. The prison repatriated Mr Tovasharov's body and contributed to the cost of the funeral in line with national policy. The deputy governor and the safer custody custodial manager met Mr Tovasharov's brother when he visited the UK in March 2017.

### Support for prisoners and staff

59. After Mr Tovasharov'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.

60. Both night orderly officers checked the other prisoners on the inpatient unit after Mr Tovasharov had been pronounced dead. The prison posted notices informing other prisoners of Mr Tovasharov's death the next day and reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected.

### Post-mortem report

61. The post-mortem report gave the cause of death as hanging. Toxicology tests detected no alcohol or drugs in Mr Tovasharov's body.

# Findings

### Risk assessment

62. Prison Service Instruction (PSI) 64/2011, which covers safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. A charge of murder, especially that of a partner, is a significant risk factor for suicide in itself. Mr Tovasharov had also recently attempted suicide and it was his first time in prison. He faced a long sentence and uncertain contact with his three children. He had yet to speak to his family about his wife's death and spoke of how difficult he found it to come to terms with what had happened.

63. Staff correctly began ACCT suicide and self-harm prevention procedures as soon as Mr Tovasharov arrived at Belmarsh and he was monitored under ACCT procedures throughout his time there. For his first four days Mr Tovasharov was constantly supervised. On 20 December, a case review decided to end constant supervision after a full mental health assessment and with the approval of the prison psychiatrist. Constant supervision should be used for short crisis periods only and we consider this was appropriate. However, we have some concerns about the onward assessment of his risk and the levels of observation set.

64. Case reviews on 17 and 18 December rightly assessed Mr Tovasharov as at high risk of suicide and self-harm. On 19 December, his risk was considered to have reduced from high to raised, despite the fact that that the psychiatrist had just broken the news to him that he had been charged with killing his wife and he was still being constantly supervised. Two days later at a review on 23 December, he was considered to be at low risk of suicide. The level of observations was reduced on four successive days from constant, to once every 15 minutes, to once every 30 minutes, to hourly, to three observations during the day and five overnight.

65. Overall, Mr Tovasharov received very good care at Belmarsh. He made a determined attempt to kill himself and we cannot say that more frequent observations would have prevented his death. However, the nature of his risk factors indicated a high risk of suicide which was unlikely to diminish in the short term. Staff relied too much on his presentation rather than these significant underlying risk factors for suicide when assessing his risk. We do not consider that Mr Tovasharov's level of risk was correctly assessed or that the level of observations adequately reflected his level of risk. We make the following recommendation:

    **The Governor and Head of Healthcare should ensure that staff make a considered, objective evaluation of all risk factors when assessing the risk of suicide and self-harm.**

### Emergency response

66. Prison Service Instruction (PSI) 03/2013 requires that the Governor must have a medical emergency response protocol in place which ensures that an ambulance is called automatically in a life-threatening medical emergency. Although the OSG radioed a code blue at 2.23am, the control room did not call an ambulance until the custodial manager asked her to tell them to do so at about 2.26/2.27am.

This is a small delay and probably did not alter the outcome for Mr Tovasharov, nevertheless every second is crucial when responding to a hanging and it is important that the practice is embedded.

67. Disappointingly, this is the fifth death at Belmarsh since April 2013 when an ambulance has not been called immediately following a code blue emergency. When the investigator visited the prison, she saw a significant number of new notices in the control room reminding staff to call an ambulance as soon as a code blue or code red is received. This is a positive sign that the prison has taken action on this matter and in the two deaths at Belmarsh since Mr Tovasharov's there has been no delay in calling an ambulance. Nevertheless, we make the following recommendation:

**The Governor should ensure that the communications room calls an ambulance immediately when a code blue or code red emergency is called.**

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