Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Terence Perkins a prisoner at HMP Belmarsh on 5 February 2018

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.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*

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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 Terence Perkins died on 5 February 2018 of acute cardiac failure at HMP Belmarsh. He was 69 years old. I offer my condolences to Mr Perkins' family and friends.

Mr Perkins had been diagnosed with heart disease before arriving at Belmarsh. I am satisfied that healthcare staff managed his condition appropriately and that his clinical care was equivalent to that which he could have expected to receive in the community.

However, I am concerned that on the day Mr Perkins died, the officer who found Mr Perkins collapsed did not have a radio to call a medical emergency code. I am also concerned that one nurse who responded appeared to panic, and that the prison was unable to confirm whether she had received any life support training. A further concern is that a prison GP trained in advance life support could not access certain life-saving equipment because the prison's healthcare department did not stock it.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **May 2019**

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Summary

Events

1. On 9 March 2016, Mr Terence Perkins was convicted of burglary and sentenced to seven years imprisonment. He was sent to HMP Belmarsh.

2. Mr Perkins had a history of ischaemic heart disease, hypertension and atrial fibrillation, and had suffered two heart attacks in the past.

3. On 11 June 2017, Mr Perkins collapsed while working and was sent to hospital. Hospital doctors thought Mr Perkins' collapse was caused by ventricular tachycardia (VT – a heart rhythm disorder) so fitted an ICD (a device that detects any life-threatening heartbeat and sends an electrical shock to the heart to correct it) into his chest. The hospital discharged Mr Perkins on 16 June and a prison GP prescribed drugs to treat heart disease.

4. Between 17 June and 23 June, Mr Perkins felt more shocks from his ICD. On 24 June, a prison GP sent Mr Perkins to the hospital's cardiology service and hospital doctors formally diagnosed him with VT. They advised changes to Mr Perkins' medication.

5. On 26 July, Mr Perkins was taken to the hospital's cardiology service for a six-week check and said that he had experienced increased breathlessness and dizzy spells. The cardiology service changed the ICD programme to try to prevent these symptoms and planned another check in six months' time.

6. On 19 September, a prison GP reviewed Mr Perkins, who said that he had been suffering with shortness of breath since his surgery in June. The GP found that Mr Perkins' oxygen saturation and pulse were normal but thought that he could be suffering with left ventricular failure so increased his medication.

7. On 20 December, a prison GP reviewed Mr Perkins as he was suffering with increased shortness of breath, fatigue and tightening in his chest. Mr Perkins said that he did not have any chest pain but the GP sent him to hospital.

8. On 9 January 2018, a clinical practitioner reviewed Mr Perkins and found that he had mild oedema (a build-up of fluid and a symptom of heart failure) in his feet, though his chest was clear. The practitioner referred him for a blood test.

9. On 30 January, Mr Perkins was ordered to pay compensation or serve a further seven year sentence.

10. On 4 February, a nurse went to Mr Perkins' cell, after being told he was unwell. Mr Perkins said that he had felt a shock from his ICD and that he felt tired, dizzy and short of breath. The nurse noted that Mr Perkins did not complain about chest pain and said that he did not want his clinical observations taken. The nurse arranged for Mr Perkins to see a GP on 6 February and told him to contact prison staff by using his cell bell if he felt unwell overnight.

11. At 8.19am on 5 February, an officer unlocked Mr Perkins' cell and found him sitting on a chair with his head rolled back. The officer called for help from another officer before using the other officer's radio to call a code blue

emergency (which indicates that a prisoner is unconscious or having difficulty breathing). Prison and healthcare staff responded to the code blue and started cardiopulmonary resuscitation (CPR). Nurses gave Mr Perkins oxygen and attached a defibrillator but it did not detect a shockable heart rhythm and advised to continue CPR.

12. Paramedics reached Mr Perkins at 8.29am, inserted an airway and gave him adrenaline. They were unable to resuscitate Mr Perkins and a prison GP, in consultation with the paramedics, declared his death at 8.54am.

Findings

Clinical care

13. We are satisfied that after Mr Perkins collapsed in 2017, healthcare staff treated his condition appropriately with regular reviews, suitable medication and by arranging urgent cardiology assessments when he experienced multiple shocks from his ICD.

14. The clinical reviewer considers that there was nothing to suggest that Mr Perkins' condition required an urgent transfer to hospital on 4 February 2018 because he said he had only had a single shock, refused further assessment and told another prisoner that he did not need to go to hospital. Subsequent examination of the ICD after Mr Perkins' death showed that in fact it had not shocked since June 2017.

15. We are satisfied that Mr Perkins' clinical care at Belmarsh was equivalent to that which he could have expected to receive in the community.

Emergency response

16. When an officer found Mr Perkins unresponsive in his cell, she had to use another officer's radio to call a code blue emergency because the prison had run out of radio batteries for her to have her own. Although this caused minimal delay because another officer was nearby, we are concerned that this could cause a critical delay in other circumstances.

17. Two officers reported that the first nurse to arrive appeared to panic and was unsure what to do. We are concerned that the prison was unable to confirm what life support training she had received. We cannot therefore rule out the possibility that a lack of recent life support training may have left her under-prepared.

18. We were also concerned that a prison GP, who responded to the code blue and who was trained in advanced life support, was unable to access an I-gel airway or adrenaline because the prison's healthcare provider did not stock them. Although paramedics inserted an airway and gave Mr Perkins adrenaline when they arrived, we are concerned that not stocking these pieces of life-saving equipment could make a critical difference in other cases.

Staff support

19. Following Mr Perkins' death, a senior prison manager held a hot debrief but the healthcare staff who had been involved in the resuscitation were not invited. We are concerned that they did not have access to the same support services as prison staff and that there was no opportunity to fully discuss and learn from the circumstances of the emergency response.

Recommendations

- The Governor should review the current provision of radios to ensure it is sufficient to meet the needs of the prison.
- The Governor and the Head of Healthcare should ensure that Oxleas Trust's policies on life support training for staff and the provision of life-saving equipment at Belmarsh:
    - are fully risk-assessed in relation to the specific situation at Belmarsh; and
    - accurately reflect the guidance of European Resuscitation Council.
- The Governor should ensure that, in accordance with PSI 64/2011, a manager holds a hot debrief promptly after a death in custody and that all those involved in the incident, including healthcare staff, are invited to attend.

The Investigation Process

20. The investigator issued notices to staff and prisoners at HMP Belmarsh informing them of the investigation and asking anyone with relevant information to contact him. Four prisoners responded.

21. The investigator visited Belmarsh on 9 February 2018. He obtained copies of relevant extracts from Mr Perkins' prison and medical records, and interviewed the four prisoners, who had responded to our investigation notices.

22. NHS England commissioned a doctor to review Mr Perkins' clinical care at the prison.

23. The investigator interviewed five members of staff at Belmarsh on 10 April. The investigator and the clinical reviewer interviewed three members of staff at Belmarsh on 20 April.

24. We informed HM Coroner for Inner South London District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

25. The investigator wrote to Mr Perkins' wife to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Perkins' daughter contacted one of the Ombudsman's family liaison officers and said that the family understood that Mr Perkins was unwell the day before he died and wanted details of what had happened.

26. The initial report was shared with HM Prison and Probation Service (HMPPS). During the consultation process, we agreed with HMPPS to amend our first recommendation. HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

27. Mr Perkins' family received a copy of the initial report. The solicitor representing Mr Perkins' family did not make any comments.

Background Information

HMP Belmarsh

28. HMP Belmarsh is a high security and local prison serving the courts of South East London and South West Essex. It holds approximately 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

29. The most recent inspection of HMP Belmarsh was in January and February 2018. Inspectors reported that healthcare had improved since their last inspection (in February 2015) and was now considered to be good, though prisoners had mixed views. They found that primary care services were good but too many patients did not attend appointments.

30. The Inspectors reported that the provision of emergency medical equipment was good, though not all officers knew where defibrillators were kept.

Independent Monitoring Board

31. 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 30 June 2017, the IMB reported that they had a good working relationship with Oxleas, though they were concerned about the number of prisoners who were not attending outpatient appointments. They also found that the prison was finding it a challenge to coordinate external appointments for prisoners, particularly as two prisoners needed dialysis three times a week.

Previous deaths at HMP Belmarsh

32. Mr Perkins was the sixth person to die of natural causes at Belmarsh since January 2015, and the ninth overall. There have been two subsequent deaths. There are no similarities between Mr Perkins' death and other deaths at the prison.

Key Events

33. On 21 May 2015, Mr Terence Perkins was remanded to HMP Belmarsh on burglary charges. On 9 March 2016, he was convicted and sentenced to seven years imprisonment.

34. Mr Perkins had a history of ischaemic heart disease, hypertension and atrial fibrillation, and had suffered two myocardial infarctions (heart attacks) in the past. He also suffered with ulcerative colitis (a long-term condition where the colon and rectum become inflamed), Type 2 diabetes and a hernia.

35. On 11 June 2017, Mr Perkins collapsed while working as a wing cleaner and an officer called for healthcare assistance. Two nurses responded and examined Mr Perkins. They took his clinical observations and found that his blood pressure was low and his pulse was very high. The nurses sent Mr Perkins to hosptial as an emergency, and from there he was sent on to another hospital.

36. Doctors at the second hospital performed an angiogram and a cardiac MRI scan and considered his symptoms were caused by ventricular tachycardia (VT – a heart rhythm disorder caused by abnormal electrical signals). On 15 June, hospital surgeons treated Mr Perkins by inserting an implantable cardioverter-defibrillator (ICD – a device that detects any life-threatening, rapid heartbeat and sends an electrical shock to the heart to correct it) into his chest. Hospital staff gave Mr Perkins an ICD guidance card that said that if he experienced one shock he should call his physician or clinic immediately, regardless of whether he had symptoms, and should consider calling 999 if he had symptoms.

37. The following day, the hospital discharged Mr Perkins back to Belmarsh. A prison GP immediately reviewed Mr Perkins and prescribed numerous drugs, including aspirin, atorvastatin, bisoprolol, clopidogrel, digoxin, furosemide, glyceryl trinitrate spray, perindopril erbumine, rivaroxaban and spironolactone (all used to treat heart disease).

38. On 17 June, a nurse saw Mr Perkins following his discharge from hospital. During the review, Mr Perkins said that he felt dizzy and had received a shock from his ICD. Mr Perkins noted, on a handwritten note found in his cell, that he felt one shock at 9.30am. The nurse did not see any signs of discomfort or distress but informed a prison GP. Later that afternoon, a prison GP saw Mr Perkins, who said that he felt well.

39. Three days later, a prison GP examined Mr Perkins, who said that he had felt a shock from his ICD. Mr Perkins' handwritten note recorded that he had felt two shocks at 9.00am. The prison GP took his clinical observations and found that his blood pressure was slightly high and his pulse was normal.

40. On 23 June, a prison GP saw Mr Perkins, who said that he had felt two shocks from his ICD. He also said that he felt dizzy and short of breath. The prison GP spoke to hospital cardiologists about Mr Perkins receiving shocks from his ICD and they asked to see him the next day.

41. On 24 June, Mr Perkins was taken to the hospital's cardiology service and hospital doctors formally diagnosed him with VT. They advised changes to Mr Perkins' medication and a prison GP replaced digoxin with amiodarone.

42. Five days later, a clinical practitioner saw Mr Perkins because his blood haemoglobin level was low at 6.3g/dl (a low level is anything below 13.5g/dl). Mr Perkins said that he felt tired and dizzy but thought this was due to his heart problems. The clinical practitioner thought that Mr Perkins had chronic anaemia.

43. On 30 June, a second blood test found Mr Perkins' blood haemoglobin level had decreased to 5.8g/dl so a prison GP sent him to hospital. While in hospital, hospital doctors performed a gastroscopy, as they thought Mr Perkins may have a gastrointestinal bleed, and gave him a blood transfusion. Although Mr Perkins went to hospital for regular blood transfusions, hospital doctors were unable to diagnose the cause of his anaemia.

44. From 5 July, healthcare staff regularly took Mr Perkins' clinical observations, including his blood pressure and pulse.

45. On 7 July, a prison GP stopped Mr Perkins' rivaroxaban prescription as he was due a colonoscopy to test for the cause of his anaemia. Four days later, Mr Perkins asked a prison GP to check this decision with the cardiology service but a consultant cardiologist confirmed that Mr Perkins needed the colonoscopy.

46. On 21 July, a prison GP examined Mr Perkins, as he felt dizzy and was short of breath. The prison GP found that his pulse was low and ordered a blood test. A clinical practitioner reviewed the results and found that they were abnormal but as expected, so took no further action.

47. On 26 July, Mr Perkins went to the hospital's cardiology service for a six-week check and said that he had experienced increased breathlessness and dizzy spells since the ICD was implanted. The cardiology service changed the ICD programme to try to prevent these symptoms and planned another check in six months' time.

48. Two days later, a prison GP restarted Mr Perkins' rivaroxaban prescription after he had the colonoscopy.

49. Mr Perkins' handwritten note recorded that he went to hospital for a check-up on 24 August and that everything was okay. Mr Perkins noted that he did not need another check-up for six months. There was no record on Mr Perkins' electronic medical record or any escort paperwork that confirmed that he went to hospital on 24 August.

50. On 12 September, a nurse saw Mr Perkins, who said that he had been suffering from shortness of breath since his surgery in June. The nurse referred Mr Perkins to the prison GP. On 19 September, a prison GP reviewed Mr Perkins and found that his oxygen saturation and pulse were normal. The prison GP thought that Mr Perkins could be suffering with left ventricular failure so increased his furosemide dosage.

51. On 18 October, a prison GP saw Mr Perkins to review his long-term conditions. Mr Perkins said that he was still dizzy but that it had improved. The prison GP planned for a blood test to be completed in three months' time.

52. On 27 October, a prison GP reviewed Mr Perkins' medication after he spent two days in hospital due to his anaemia. The prison GP stopped Mr Perkins' clopidogrel and rivaroxaban prescriptions and prescribed apixaban (an anticoagulant used to prevent blood clots).

53. On 20 December, a prison GP reviewed Mr Perkins as he was suffering with increased shortness of breath, fatigue and tightening in his chest. Mr Perkins said that he did not have any chest pain but the prison GP sent him to hospital for a blood transfusion.

54. On 9 January 2018, a clinical practitioner reviewed Mr Perkins and found that he had mild oedema (a build-up of fluid and a symptom of heart failure) in his feet, though his chest was clear. The clinical practitioner arranged for a blood test in two weeks.

55. On 17 January, a prison GP saw Mr Perkins to review his long-term conditions. Mr Perkins said that he felt tired and was short of breath but the prison GP found that he was haemodynamically stable (had a stable heart pump and good circulation of blood). The prison GP referred Mr Perkins to hospital for another blood transfusion.

56. Three days later, Mr Perkins told a nurse that he wanted to return his digoxin prescription as he did not need it. The nurse explained why Mr Perkins needed the medication but he insisted that he did not want it.

57. On 23 January, a prison GP reviewed Mr Perkins' blood test results and found that his NT-Pro-BNP rate (a test to detect and evaluate the severity of heart failure) was high at 178 pmol/L (a normal rate is anything below 47 pmol/L). The prison GP referred Mr Perkins to another prison GP.

58. On 30 January, a clinical practitioner saw Mr Perkins and took his clinical observations. His blood pressure and pulse were normal, at 120/70 and 90bpm respectively.

59. Also on 30 January, Mr Perkins was ordered to pay over £6.5 million in compensation or serve a further seven-year sentence.

60. On 4 February, a prisoner told an officer that Mr Perkins needed to see a nurse. The officer asked a nurse to see Mr Perkins and she immediately went to his cell. Mr Perkins told the nurse that he had felt a shock from his ICD and that he felt tired, dizzy and short of breath. The nurse noted that Mr Perkins did not complain about chest pain and was not slurring when talking. She told the investigator that Mr Perkins did not want his clinical observations taken because he was watching an England rugby union match. The nurse arranged for Mr Perkins to see the doctor on 6 February and told him to contact prison staff by ringing his cell bell if he felt unwell overnight.

61. Another prisoner told the investigator that he and two other prisoners tried to get Mr Perkins to go to hospital but he did not want to go. The officer also told the

investigator that Mr Perkins said that he was fine and she got the impression that he did not want her to worry about him.

62. Mr Perkins' handwritten note recorded that he had felt three shocks at 3.45pm. (After Mr Perkins' death, his ICD was examined by a hospital principal cardiac psychologist who found that the ICD had not delivered any shocks between 26 July 2017 and 5 February 2018.)

63. At approximately 8.00pm, an operational support grade (OSG) officer said she checked on Mr Perkins and saw that he was in bed. The OSG officer said she did not talk to Mr Perkins because she was aware that he had been unwell and did not want to wake him.

Events on 5 February 2018

64. At approximately 4.45am on 5 February, the OSG officer said that she checked on Mr Perkins and saw that he was still in bed asleep.

65. At approximately 8.10am, two officers started unlocking cells on Mr Perkins' wing, beginning on the second floor and working down to the ground floor. At 8.19am, one of the officers unlocked Mr Perkins' cell, which was the last to be unlocked, and found him sitting on a chair with his head rolled back. The officer noticed that Mr Perkins' face was very pale. She called his name but got no response. She then called for help from the other officer, who was talking to a prisoner in the neighbouring cell. The second officer entered Mr Perkins' cell and found that he was unresponsive.

66. The first officer used the second officer's radio to call a code blue emergency (which indicates that a prisoner is unconscious or having difficulty breathing) because she had not been provided with her own radio. She was not sure that the call had gone through, so the second officer called a second code blue. The control room had received the first code blue and they immediately called an ambulance. The London Ambulance Service noted that an ambulance was requested at 8.20am

67. Numerous members of staff responded to the code blue, including four officers and a nurse. They placed Mr Perkins on the floor and started cardiopulmonary resuscitation (CPR). One of the officers told the investigator that the nurse appeared to panic and seemed unsure how to respond but two other nurses and a prison GP quickly arrived and took over the resuscitation. The nurses gave Mr Perkins oxygen and attached a defibrillator but it did not detect a shockable heart rhythm and advised to continue CPR.

68. The first set of paramedics reached Mr Perkins at 8.29am, closely followed by other paramedics. They decided to move Mr Perkins onto the landing, inserted an airway, gave him six doses of adrenaline and continued CPR. However, they were unable to resuscitate Mr Perkins and a prison GP, in consultation with the paramedics, declared his death at 8.54am.

Contact with Mr Perkins' family

69. After Mr Perkins was taken to hospital on 11 June 2017, the prison appointed a senior officer as the prison's family liaison officer. The senior officer had

occasional contact with Mr Perkins' daughters between 11 June and 21 December whenever his condition deteriorated.

70. Following Mr Perkins' death, the prison appointed a prison manager as a deputy family liaison officer. At 11.10am on 5 February, the senior officer and the prison manager visited Mr Perkins' wife at home to break the news of his death and to offer their condolences and support.

71. The senior officer continued to support Mr Perkins' wife and other family members until his funeral. Mr Perkins' funeral was held on 8 March 2018 and the prison paid for the costs of the funeral in line with national instructions.

Support for prisoners and staff

72. After Mr Perkins' death, a senior prison manager debriefed the prison 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.

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

Post-mortem report

74. The post-mortem report found that Mr Perkins died from acute cardiac failure caused by arrhythmogenic heart disease (a condition that causes abnormal heart rhythms) associated with cardiomegaly (an abnormal enlargement of the heart).

Findings

Clinical care

75. Mr Perkins had been diagnosed with heart disease before he arrived at Belmarsh in May 2015 and his condition was relatively stable until June 2017. When Mr Perkins collapsed on 11 June, we are satisfied that two nurses sent him to hospital promptly for treatment. In the days after surgeons fitted the ICD, Mr Perkins experienced further shocks and we are satisfied that prison healthcare staff arranged an urgent cardiology assessment. We are also satisfied that they prescribed Mr Perkins appropriate medication to treat his heart disease and irregular contractions of his heart.

76. On 4 February 2018, a nurse saw Mr Perkins promptly at the request of another prisoner and an officer when Mr Perkins reported feeling unwell. He told the nurse that he had felt a shock from his ICD. (After Mr Perkins' death an examination of his ICD found that the ICD did not shock Mr Perkins between the episodes in June 2017 and the day of his death. Although the ICD had not actually shocked Mr Perkins on 4 February 2018, he apparently believed that he had been shocked.)

77. After seeing Mr Perkins, a nurse made the decision that further assessment could wait until 6 February when Mr Perkins would see one of the prison's GPs. The nurse told the investigator that she reached this decision because Mr Perkins said he had only had a single shock, he refused further assessment or examination, and he looked well.

78. In support of the nurse's statement, we note that Mr Perkins ignored another prisoner's suggestion that he go to hospital and had told an officer that he felt fine. We therefore accept the clinical reviewer's conclusion that there was nothing to suggest that Mr Perkins' condition required an urgent transfer to hospital on 4 February or that the nurse's management of the alleged shock was inappropriate.

79. We are satisfied that the clinical care Mr Perkins received at Belmarsh was equivalent to that which he could have expected to receive in the community.

Emergency response

80. When an officer found Mr Perkins unresponsive in his cell, she had to use another officer's radio to call a code blue emergency. She told the investigator that the prison had run out of radio batteries so she could not have her own radio. Although we are satisfied that this only caused a minimal delay in calling the code blue (as the second officer was in the cell next door), we are concerned that a lack of available, working radios could cause unnecessary delays in other circumstances. We consider that all operational staff should have access to their own radio to allow emergency codes to be called without any delay.

81. Once the officers called the code blue, numerous prison and healthcare staff responded. An officer told the investigator that he felt that the first nurse who responded appeared to panic and was unsure what to do. Another officer wrote the same thing in his staff statement. We understand that the nurse has

resigned from Oxleas NHS Foundation Trust, the healthcare provider at Belmarsh, so we have not been able to find out whether there was an explanation for her apparent panic and what life support training she had received. Belmarsh was unable to confirm what life support training the nurse had received, though they confirmed that the two other nurses who responded had received extended basic life support training. While the other nurses were appropriately trained, we are concerned that the first nurse may not have not received any recent life support training, which may have caused her to panic.

82. A prison GP told the investigator that despite being trained in advanced life support, he was unable to access an I-gel airway or adrenaline because Oxleas do not stock them. He explained that Oxleas only require their staff to be trained in basic life support. While we cannot be say whether the lack of immediate access to an I-gel airway or adrenaline affected the outcome for Mr Perkins, we are concerned that not training healthcare staff in intermediate life support training or stocking these pieces of life-saving equipment could have an impact in the future. It is unclear to us if Oxleas' policy on staff training and equipment has been fully risk assessed in relation to the situations found in a prison with an in-patient unit and on-site teams of clinicians, as opposed to the environments in which the Trust operates elsewhere.

83. We make the following recommendations:

The Governor should review the current provision of radios to ensure it is sufficient to meet the needs of the prison.

The Governor and the Head of Healthcare should ensure that Oxleas Trust's policies on life support training for staff and the provision of life-saving equipment at Belmarsh:

- **are fully risk-assessed in relation to the specific situation at Belmarsh; and**
- **accurately reflect the guidance of European Resuscitation Council.**

Staff support

84. PSI 64/2011 sets out the actions that should be taken following a death in custody. This includes that a hot debrief must be held immediately after a death in custody and that all staff directly involved in the incident, including healthcare staff, should be invited.

85. On 5 February, following Mr Perkins' death, a senior prison manager held a hot debrief with the prison staff directly and indirectly involved in his death, but healthcare staff were not invited. During the hot debrief, the attendees discussed the circumstances of the emergency response and a member of the prison's care team reminded them about the Employee Assist programme and local care and welfare services.

86. Because healthcare staff were not included, we are concerned that they did not have access to the same support services as were offered to prison staff and that there was no opportunity to fully discuss and learn from the circumstances of the emergency response. We make the following recommendation:

The Governor should ensure that, in accordance with PSI 64/2011, a manager holds a hot debrief promptly after a death in custody and that all those involved in the incident, including healthcare staff, are invited to attend.

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