

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ravinder Multani a prisoner at HMP Bullingdon on 10 May 2016

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

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Mr Multani was found dead in his cell at HMP Bullingdon on 10 May 2016. Post-mortem examinations were unable to ascertain the cause of his death. Mr Multani was 34 years old. I offer my condolences to Mr Multani's family and friends.

There was inconsistency between staff's views about how well Mr Multani could speak English. Those who spoke to him in reception were confident that they could communicate with him adequately, but officers on the wing felt that there was a language barrier. I am concerned that this inhibited wing staff from referring Mr Multani to the healthcare department when he appeared to be agitated or under stress. It was also a potential factor in Mr Multani not having a full induction programme alongside other new prisoners. I have raised concerns around the management of non-English speakers at Bullingdon previously.

I am also concerned that the nurse carrying out the reception medical screening was unaware of Mr Multani's offence. This meant she was unaware that his claim not to drink alcohol was untrue and she was therefore unable to make a full assessment of his condition. Bullingdon's policy of not conducting secondary health screenings, which breaches Prison Service guidance, meant that there was no second opportunity to reassess Mr Multani with this issue in mind. There were, however, no reasons for staff to think that Mr Multani was in imminent danger, and no indication that they could have prevented what happened.

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

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Summary

Events

1. On 6 May 2016, Mr Ravinder Multani, an Indian national, was convicted of offences related to drink driving and sentenced to 12 weeks imprisonment. He was taken to HMP Bullingdon.
2. His escort papers noted that Mr Multani spoke Punjabi and did not speak English but reception staff at Bullingdon said that they were able to communicate with him without the aid of the interpreting service used by the prison. A nurse who conducted a reception health screening said she felt able to communicate with him without using an interpreter. She was unaware of his offence and, as Mr Multani told her that he did not drink alcohol, she did not consider referring him for a detoxification programme.
3. Mr Multani's behaviour over the weekend was agitated, disruptive and bizarre. During the night, he banged on his door but wing staff were unable to ascertain what was wrong due to language difficulties. Prisoners noticed him acting in an odd manner during exercise as well as on the wing. Officers were unable to find out why Mr Multani was agitated. Another prisoner with the relevant language skills spoke to him, asking Mr Multani whether he needed a doctor or any medication, but Mr Multani said he did not. He told the prisoner that he had problems outside prison.
4. Mr Multani was due to attend an induction session on the afternoon of Monday 9 May. Wing staff, however, did not allow him to attend. The reasons for this were not documented, although it was suggested that they were concerned that his behaviour might make him vulnerable, and doubted his capacity to understand the information that would be presented.
5. On 9 May, at approximately 10.10pm, Mr Multani pressed his cell bell. The night officer went to Mr Multani's cell but was unable to understand what he was saying. He indicated non-verbally to Mr Multani to go to sleep. Mr Multani nodded and lay down on his bed. The officer conducted a roll check of the wing at approximately 4.30am and did not notice anything of concern.
6. At approximately 8.43am, an officer unlocked Mr Multani's cell door and found him lying on the floor. He made an emergency call on his radio and staff went into the cell. They began to turn Mr Multani over in an attempt to resuscitate him but a nurse in attendance assessed him and said that resuscitation was futile as Mr Multani was clearly dead.

Findings

7. When Mr Multani arrived in Bullingdon he told the nurse who conducted his reception health screening that he did not drink alcohol. He had been convicted of drink-driving but as the nurse did not have access to that information she had to take him at his word and did not refer him for detoxification or further assessment. Moreover, contrary to Prison Service guidance, Bullingdon did not offer a secondary health screening so healthcare staff had no further opportunity to assess Mr Multani.

8. It has been difficult to establish how well Mr Multani spoke English. Reception staff were confident that they could communicate adequately with him, but wing staff found that there was a language barrier. When Mr Multani began to display unusual behaviour on the wing and in the exercise yard, wing staff were unable to clarify with him what was wrong. They assumed that he was detoxifying from alcohol, but nobody checked with the healthcare team, and once more an opportunity to assess Mr Multani was lost. When Mr Multani rang his cell bell during the night, staff could not understand what he was saying. He did not appear to be in distress, but nobody called for a member of the healthcare team to check him or attempted to clarify what he wanted.
9. When Mr Multani was found dead on the morning of 10 May, the emergency response was reasonable. Mr Multani had clearly been dead for some time, and attempting to resuscitate him would not have been appropriate. The emergency response nurse collected a medical emergency bag on her way to Mr Multani's cell, despite there being an emergency bag on the wing, as she was not confident it had been maintained correctly. Another nurse was already on the wing so in this instance there was no delay in the provision of medical assistance but in another case such a diversion could cause delay and should be addressed.

Recommendations

- The Governor and Head of Healthcare should ensure that reception staff have all available information to allow them to assess a prisoner's risks and wellbeing.
- The Governor should ensure that wing staff report to the healthcare team any behaviour that might cause concern.
- The Governor should ensure that induction procedures are delivered in line with Prison Service Instruction (PSI) 7/2015, *Early Days in Custody*, and that all newly-arrived prisoners receive essential information about prison processes.
- The Head of Healthcare should ensure that prisoners are offered a secondary health screening in line with PSO 3050, *Continuity of Healthcare for Prisoners*.
- The Head of Healthcare should ensure that emergency response staff are confident where emergency equipment is located, and that it is properly maintained.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Bullingdon informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator visited Bullingdon on 17 May. He obtained copies of relevant extracts from Mr Multani's prison and medical records.
12. The investigator interviewed six members of staff and four prisoners at Bullingdon.
13. NHS England commissioned a clinical reviewer to review Mr Multani's clinical care at the prison. He joined the investigator for interviews of healthcare staff.
14. We informed HM Coroner for Oxfordshire of the investigation and he sent us the results of the post-mortem examination. We have given the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Multani's uncle to explain the investigation and to ask whether he had any matters he wanted the investigation to consider. He asked for confirmation of whether Mr Multani had been calling out from his cell the night during that he died. Mr Multani's uncle received a copy of the initial report. He did not make any comments.

Background Information

HMP Bullingdon

16. HMP Bullingdon is a training and local prison, serving the courts of Oxfordshire and Berkshire. It holds up to 1,114 men. Care UK provides healthcare services. There is 24-hour healthcare cover with doctors in the prison seven days a week in ordinary office hours and at least two nurses on duty during the night. There is a 20-bed in-patient unit.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Bullingdon was in June 2015. Inspectors reported that while relationships between staff and prisoners were generally good, this was not underpinned by effective strategies to ensure prisoners' needs were met. Inspectors were concerned at the limited interpretation services available to newly-arrived non-English speaking prisoners. Foreign national prisoners who spoke little English said that they received little help from staff. Healthcare provision was reasonably good. Induction programmes were not always provided promptly, particularly for non-English speaking prisoners.

Independent Monitoring Board

18. 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 31 July 2015, the IMB reported that officers working on reception often did so under pressure. The board also noted that NHS funding for dedicated members of staff to deal with detoxification issues was withdrawn in April 2015.

Previous deaths at HMP Bullingdon

19. Mr Multani's was the eighth death at Bullingdon since the beginning of 2015. There has since been another. The other deaths bore no clear similarities to that of Mr Multani but in a report published in November 2015 we made recommendations about prisoners who do not speak English. In our annual report for 2015-2016 we point out the difficulties that can face prisoners who do not have English as their first language.

Key Events

20. On Friday 6 May 2016, Mr Ravinder Multani was sentenced to 12 weeks imprisonment for drink-driving offences and was taken to HMP Bullingdon. It was his 34th birthday. He was born in India and had been in the United Kingdom since 2009. He had a number of previous convictions, including offences of drink-driving.
21. The warnings section of the papers that arrived at the prison with Mr Multani did not highlight any concerns. His personal prisoner record, which was begun by GEO Amey staff escorting him from court to prison, noted that Mr Multani was unable to read or write English, and that he spoke Punjabi.
22. An officer interviewed Mr Multani in reception. She told the police that she had no difficulty in communicating with Mr Multani. She said his English was good enough for her not to need to use Language Line (the telephone interpretation service used in the prison) although it was available had she thought she required it.
23. A nurse conducted Mr Multani's initial health screening. She noted on his record that his main language was English. Mr Multani told her that he was not a drug user, and that he had never received treatment or medication for mental health problems. She is a mental health nurse, as well as a general nurse, and said in interview that she did not see any signs of mental health issues. Mr Multani said that he did not drink alcohol, and she said that she did not note any signs of alcohol withdrawal. Mr Multani said that he had no concerns over his physical health, was not taking any medication, and had no outstanding doctor or hospital appointments. The nurse noted that he appeared to be fit and healthy.
24. As part of the reception process, trained prisoners, known as Insiders, see new arrivals to provide peer advice and information about how prison works from a prisoner's perspective. Two prisoners saw Mr Multani. They told the investigator that he appeared to be in a state of shock. They spoke to him but he did not answer so they were unable to gauge whether he spoke English or understood them. They gave him some papers with information for prisoners, and although he took them Mr Multani did not look at them. Once again, they were unable to tell if he understood English.
25. Mr Multani was allocated a cell on F wing, the reception and induction wing. A prisoner on F wing told the investigator that throughout the night of 6 May he could hear Mr Multani banging on his cell door. He said that the following morning, Saturday 7 May, Mr Multani was apologising to other prisoners on the wing for the noise.
26. On 7 May, an officer completed Mr Multani's basic custody screening form. He noted that Mr Multani had said that he could read and write, and found understanding, reading, writing and speaking English easy. He told the police that Mr Multani spoke English and that he had no need to use Language Line.
27. At 2.10pm, Mr Multani made a telephone call. He spoke to a woman in Punjabi. He said that he was fine, and had been sentenced to six weeks imprisonment.

He said that he had to keep the telephone call short because he had only limited funds.

28. A prisoner who had lived near Mr Multani before coming to prison and had arrived in Bullingdon at the same time said he recognised him and, on 7 May, they spoke to each other in English. Mr Multani was shaking and said that he needed alcohol. The prisoner told the police that when he tried to speak to him after this occasion, Mr Multani would only speak in Punjabi, however, a language he did not have, so they did not converse further.
29. On the evening of 8 May, when prisoners were locked into their cells, Mr Multani began to bang on his cell door. The night officer went to his cell. Mr Multani spoke to her in a language she did not understand and she was unable to establish what was wrong. He calmed down but at approximately 10.00pm began to bang on his door again. She and a colleague could not persuade him to stop so she radioed the night orderly officer (in charge of the prison during the night) and asked him to come to the wing. By the time he arrived, however, Mr Multani had stopped. They checked on Mr Multani several times during the night, and each time he was standing or pacing in his cell, or sitting on the bed talking to himself. When they asked him if he was alright, he answered in a language they were unable to understand. She noted what had happened in the wing observation book. When prisoners were unlocked in the morning, some prisoners tried to remonstrate with him about the noise during the night. Two prison officers stood by the door to ensure that they did not do Mr Multani any harm.
30. During the morning of Monday 9 May, an officer noticed Mr Multani going in and out of other prisoners' cells, apparently looking for something. He asked him what he wanted, but Mr Multani did not answer in English. A prisoner who spoke a number of languages heard what was happening and asked the officer if he could speak to Mr Multani. The prisoner told the investigator that Mr Multani was initially very upset, but would not elaborate on what was wrong beyond that he had problems outside prison. He asked him if he needed a doctor or if he needed any medication, but Mr Multani said that he did not. Mr Multani eventually calmed down, and he told the officer that Mr Multani was fine.
31. Later that morning a prisoner was in the exercise yard with another prisoner, when Mr Multani approached them. At first, they thought his manner was threatening and told him to go away. Mr Multani did not speak, but did move away. They watched him, and saw that he was behaving in an odd manner and looked confused. He was walking around talking to himself, trying to open the gates out of the yard. They realised that they were standing in front of one of the gates and that might have been why he had approached them.
32. New prisoners go through an induction process during their early days in prison. Because Mr Multani had arrived late in the day on a Friday he was unable to undergo the induction that evening and was therefore due to attend an induction session on Monday afternoon. When the time arrived, officers on the wing decided that he should not attend. The reasons for this were not documented, although it was suggested that they were concerned that his behaviour might

make him vulnerable, and doubted his capacity to understand the information that would be presented.

33. At about 5.00pm, Mr Multani came out of his cell barefoot. Officers told him that he was not allowed on the landing without shoes, and an officer escorted him back to his cell and tried to explain that he was not allowed out without shoes. He told the investigator that he was not convinced that Mr Multani understood him. Another prisoner heard the exchange and came into the cell. He spoke to Mr Multani in a language the officer did not understand, and Mr Multani then put his shoes on and came out of the cell. Later, Mr Multani approached an officer and asked for food, but the officer said that he spoke little English and asked using gestures. He took Mr Multani to his cell where his dinner was on his table so he pointed it out.
34. At approximately 6.15pm, an officer locked prisoners, including Mr Multani, into their cells. He told the investigator that Mr Multani seemed fine at this time.
35. Officer A was the night patrol officer on F wing that night. He told the police that at approximately 10.10pm Mr Multani pressed his cell bell. He went to the cell and asked Mr Multani what he wanted. Although Mr Multani was calm and seemed relaxed, he spoke in a foreign language and he could not understand him. He used hand signals to indicate that Mr Multani should get some sleep. Mr Multani smiled, nodded, and lay down on his bed. He told the police that he considered asking whether there were any staff on duty who spoke Mr Multani's language, but as the prison was in night state and staffing numbers were lower than during the day, he decided against it. He said that he had no reason to be concerned about Mr Multani's wellbeing. Mr Multani did not press his cell bell again that night and he had no reason to check on him further. The prisoner in the cell next door to Mr Multani's told the investigator that he did not hear any noise from Mr Multani's cell during the night.
36. On 10 May, Officer A conducted a roll check at approximately 4.30am. This involved confirming the presence of each prisoner through the cell observation panel. He told the police that he did not specifically recall what Mr Multani was doing at the time of this check, but said that he would have noticed if he had been lying on the cell floor. He saw nothing that gave him any cause for concern.
37. Officer B came on duty on F wing later that morning to take over from night staff. When unlocking prisoners' cell doors, he arrived at Mr Multani's cell at approximately 8.43am. As he did so, he looked into the cell and saw Mr Multani face down on the floor with fluid and blood coming from his mouth. He used his radio to call a code blue emergency indicating that a prisoner is having difficulty breathing or not breathing at all. He also shouted for help. On hearing the code blue call, the control room automatically requested an ambulance. He went into the cell and spoke to Mr Multani, but received no response. He checked him for a pulse, but was unable to find one. Other staff arrived and another officer also checked Mr Multani for a pulse. He was unable to find one, so tried to turn Mr Multani over to begin attempts to resuscitate him. Mr Multani, however, was showing clear signs of rigor mortis.
38. The nurse who was the designated emergency responder, while she was on her way to F wing, went to collect an emergency response bag. During this delay,

the nurse who was based on F wing arrived. He checked Mr Multani and confirmed that he was dead, and when other nurses arrived they agreed that any attempt to resuscitate him would be inappropriate. One of the prison's doctors arrived. At 9.00am, he confirmed that Mr Multani had died, commenting that he had been dead for some time.

Contact with Mr Multani's family

39. One of the prison's managers was appointed as family liaison officer. After some investigation, she identified an uncle of Mr Multani's as his nearest relative in the United Kingdom and told him of Mr Multani's death. In line with Prison Service protocol, Bullingdon offered to contribute to the cost of the funeral.

Support for prisoners and staff

40. After Mr Multani's death, the 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.
41. The prison posted notices informing other prisoners of Mr Multani'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 Multani's death.

Post-mortem report

42. Post-mortem examinations were unable to ascertain the cause of Mr Multani's death. There were no indications that he had been assaulted and there were no illicit drugs in his system. Examinations did show results that the pathologist could attribute to long-term alcohol misuse.

Findings

43. Mr Multani had been convicted of drink-driving and had previous convictions involving alcohol. When he saw the nurse, however, he told her that he did not drink. She was not aware of his offence and had to take his word. He was not, therefore, referred for detoxification treatment, nor were any plans put in place to help him if his health suffered accordingly. It is difficult for staff to accurately gauge a prisoner's risks or needs unless they have all the necessary information available. We make the following recommendation.

The Governor and Head of Healthcare should ensure that reception staff have all available information to allow them to assess a prisoner's risks and wellbeing.

44. In his short time in Bullingdon, Mr Multani displayed some agitated, disruptive and bizarre behaviour. He banged on his cell door during the night but would not say what he wanted. He wandered in and out of other prisoners' cells. He wandered round the exercise yard trying the locks on the gates. Mr Multani was shaky and sweating, and two officers both said that they thought he was showing signs of detoxification. They both assumed that if this was the case, the healthcare team would be aware and would be supplying anything he needed. They were all unable to ascertain what was wrong when Mr Multani was banging on his cell door during the night, but did not try to clarify any further why he was making a noise.
45. Many newly-arrived prisoners are detoxifying from drug or alcohol use. Additionally, arriving in prison can be a traumatic experience and can affect the way a person behaves in his or her early days in custody. Staff working in reception areas may witness many types of unusual behaviour. Prison officers do not have medical training and must, rightly, rely on healthcare services to fulfil that role. For reasons of medical confidentiality, prison officers do not have knowledge of the treatment prisoners are receiving. In Mr Multani's case, problems clarifying his wellbeing were exacerbated by his not speaking English. None of the prison or night patrol officers who dealt with Mr Multani in Bullingdon had any reason to suspect that he was dangerously unwell or in distress. However, early days in custody are a time when prisoners can be particularly vulnerable. If prison officers witness prisoners displaying unusual behaviour, rather than assuming that they are under medical care they should check with the healthcare team.

The Governor should ensure that wing staff report to the healthcare team any behaviour that might cause concern.

Induction

46. Mr Multani did not have an induction when he arrived at Bullingdon because it was a Friday afternoon. The process was not available over the weekend, so he was due to attend an induction on the Monday afternoon. When the time arrived, however, wing staff did not allow Mr Multani to attend. There is no documentation to show who took this decision nor why they did so. However, wing officers suggested in interview that it might have been because Mr Multani's behaviour would put him at risk from other prisoners, and/or because they were

not confident he would have been able to absorb the quantity of information being presented.

47. Prison Service Instruction 7/2015 states that prisoners should receive information about prison life. The instruction says that inductions should be given within five days of prisoners' arrival. There is no record that any staff explored Mr Multani's induction needs with him or that he received an appropriate induction. Although he died within the stipulated five day period, Mr Multani was displaying agitated, disruptive and bizarre behaviour and it should have been apparent that he might need some support. A proper induction would have informed him of the support he could get from the chaplaincy, Listeners (prisoners trained by the Samaritans to offer support) and other support agencies, and how to raise any concerns he had. In its most recent inspection of Bullingdon, HM Inspectorate of Prisons found that induction programmes were not always provided promptly, particularly for non-English speaking prisoners. While Bullingdon have been unable to provide us with a reason why Mr Multani was not allowed to attend his induction on 9 May, we are concerned that alternative plans were not put in place. We make the following recommendation:

The Governor should ensure that induction procedures are delivered in line with PSI 7/2015, *Early Days in Custody*, and that all newly arrived prisoners receive essential information about prison processes.

Mr Multani's language

48. Police reports show that Mr Multani's GP records gave his main spoken language as Punjabi. His family told the police that he spoke enough English to manage daily life. The police officer who arrested him said that he spoke English, but when his arrest was being processed at the police station staff used an interpretation service. This is standard procedure when a prisoner's first language is not English. For informal procedures in the police station, staff said Mr Multani's English was sufficient to communicate.
49. When required, Bullingdon use a translation service called Language Line. If a translator is needed in the reception area, an office is available containing a conference call telephone and instructions on how to use Language Line. Staff said that the service is easy to use, and records show that Bullingdon used the Language Line service on four occasions for other prisoners during the time that Mr Multani was in the prison.
50. The escort papers that arrived at Bullingdon with Mr Multani said that his main language was Punjabi and that he could not read or write English. However, the officer who saw him in reception said that she had no difficulties in communicating with him. A nurse also said that she had no problems in communicating with Mr Multani and although she was aware of the availability of the Language Line interpretation service she felt no need to use it.
51. Prison officers on F wing, however, said that Mr Multani had a poor grasp of English. While they managed to convey basic information such as where he could access his food or the requirement that he needed to wear shoes outside his cell, this was mainly achieved by hand signals, or with another prisoner's assistance. A prisoner told the police that he and Mr Multani spoke to each other

in English on 7 May, but when he saw him subsequently Mr Multani refused to speak English and would only speak Punjabi. It is possible, then, that Mr Multani was able to speak English but for whatever reason decided not to.

52. It is important that prison staff dealing with prisoners are able to understand them and *vice versa*. Bullingdon have been unable to provide evidence as to why Mr Multani was not allowed to attend his induction. If this had been because there were concerns that he would not be able to understand the language, but staff had not made efforts to engage an interpretation service, then we would have made a recommendation. We have previously made recommendations to Bullingdon about ensuring that interpreting services were available and used where necessary. The staff in reception who had important dealings with Mr Multani were both quite clear that they were able to communicate with him so we do not repeat our recommendation.

Mr Multani's healthcare

53. A nurse conducted Mr Multani's reception health screening. She said that she did not observe any signs of mental health problems or symptoms of alcohol withdrawal. In conjunction with Mr Multani's statement that he had not drunk any units of alcohol that week, she felt no reason to refer him for a detoxification programme or for a mental health assessment.
54. Prisoners arriving in prison are under a degree of stress, and an initial health screening may not pick up the full picture of their health. Prison Service Order (PSO) 3050, *Continuity of Healthcare for Prisoners*, provides guidance on healthcare. The PSO states that within a week of the first reception assessment all prisoners should be offered a general health assessment. Bullingdon did not offer prisoners a secondary health screening as a matter of policy.
55. An officer said in interview that prison officers would assume that newly-arrived prisoners would have seen a doctor and, if necessary, been referred to the detoxification team. Prison officers would therefore assume that the healthcare team were aware of prisoners who appeared to be withdrawing from alcohol or drug use, and would not draw odd behaviour to the healthcare team's attention. This leaves a potential gap in care, and a secondary health screening would be a further opportunity for the healthcare team to assess new prisoners. The clinical reviewer recommended that this should be remedied, and we agree. We make the following recommendation.

The Head of Healthcare should ensure that prisoners are offered a secondary health screening in line with PSO 3050, *Continuity of Healthcare for Prisoners*.

56. The clinical reviewer had no concerns over the medical response when Mr Multani was found in his cell on 10 May. The decision not to attempt to resuscitate him was appropriate as Mr Multani had clearly been dead for some time.
57. When the nurse, who was the designated emergency medical responder, heard the emergency call on F wing, she diverted her journey there to pick up an emergency bag. This was despite there being an emergency bag on F wing

already. She said in interview that although she knew that there was a bag on the wing, she was not confident that it would be correctly stocked. She also said that the second emergency bag was cumbersome and slowed her progress. In this instance it did not affect the outcome, but in emergency situations seconds can be vital and such a diversion could affect the outcome in future. Response staff should not feel obliged to create what may be unnecessary delays in emergencies. We make the following recommendation.

The Head of Healthcare should ensure that emergency response staff are confident where emergency equipment is located, and that it is properly maintained.

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