Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Marlon Watson a prisoner at HMP Dovegate on 29 September 2018

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.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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

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

Mr Marlon Watson died on 29 September 2018 after being found hanging in his cell at HMP Dovegate. He was 32 years old. I offer my condolences to Mr Watson's family and friends.

Mr Watson had a history of illicit drug use and of depression. He was repeatedly offered help and support for his substance misuse but chose not to engage. Intelligence suggested that he was involved in smuggling drugs into the prison.

On the day before his death, after speaking to his partner, Mr Watson apparently believed their relationship was over. Staff were not aware of this. Toxicology tests found that Mr Watson had used psychoactive substances immediately before his death and it is possible that this affected his mood and his behaviour before he hanged himself.

Mr Watson had no history of self-harm or suicide attempts. I am satisfied that staff had no reason to consider that he posed a risk to himself and could not have been expected to foresee that he would take his life.

I am concerned there was a delay before an ambulance was called when Mr Watson was found hanging. Although this did not affect the outcome for Mr Watson, such delays could make the difference between life and death in other cases.

I am also concerned about the availability of drugs at Dovegate. The prison is not alone in facing this problem and I have once again recommended that the Prison Service should produce guidance for establishments on the best ways of reducing the supply and demand for drugs.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **May 2019**

Contents

Summary

Events

1. Mr Marlon Watson had a significant history of illicit drug use. He also had a history of depression.

2. Mr Watson had a history of convictions for robbery, possession of a firearm, theft and other offences. He was released on licence in March 2016, having been in custody since November 2014.

3. On 17 April 2017, Mr Watson was recalled to custody, charged with robbery and possession of a firearm, and sent to HMP Leicester. On 27 June 2017, Mr Watson was convicted and sentenced to nine years four months.

4. On 5 October 2017, Mr Watson transferred from Leicester to HMP Dovegate.

5. Mr Watson's medical and security records show that while at Dovegate he used both illicit drugs and alcohol. He was offered support by substance misuse services, but chose not to engage.

6. On 28 September 2018, Mr Watson spoke to his partner on the phone. As a result, he apparently believed that their relationship was over and that she was in a new relationship

7. On 29 September, at 9.16am, a member of staff found Mr Watson hanging in his cell. An ambulance was requested, staff began cardiopulmonary resuscitation and continued until paramedics arrived. Paramedics took over emergency treatment, but at 9.52am, pronounced Mr Watson dead.

8. The toxicology tests found that Mr Watson had used psychoactive substances (PS) immediately before his death.

Findings

Assessment of risk

9. It appears that the day before his death, following a phone call to his partner, Mr Watson believed that their relationship had ended. This was not known to prison staff.

10. Mr Watson had no recorded history of self-harm or attempted suicide. We do not consider that staff at Dovegate had any reason to consider that he presented a risk to himself or that they could have foreseen or prevented his death.

Clinical care

11. The clinical reviewer concluded that the care provided to Mr Watson was equivalent to that which he could have expected to receive in the community. He was prescribed medication for depression but did not always attend GP appointments.

Psychoactive Substances

12. Mr Watson had a long history of abusing illicit drugs, including psychoactive substances (PS) commonly known as 'spice', and intelligence suggested that he was involved in smuggling drugs into the prison. He was repeatedly offered help and support by substance misuse staff but chose not to engage.

13. Toxicology tests show that Mr Watson used PS immediately before his death, and it is possible that this affected his mood and behaviour.

14. We are concerned at the ready availability of illicit drugs at Dovegate. We have previously recommended that the Chief Executive of HM Prison and Probation Service (HMPPS) should issue detailed national guidance on measures to reduce the supply and demand of drugs, including PS, in prisons. The Chief Executive told us in response that HMPPS planned to issue a national drug strategy in the autumn of 2018. We are concerned that at the time of writing (March 2019), HMPPS has still not issued the strategy.

Emergency response

15. The prison staff who discovered Mr Watson hanging in his cell staff correctly used a medical emergency code and healthcare staff arrived quickly. However, there was an apparent five-minute delay before the control room called an emergency ambulance. Although this did not affect the outcome for Mr Watson, it could be crucial in other emergencies.

Recommendations

- The Director should ensure that control room staff call an ambulance as soon as a medical emergency code is broadcast.
- The Chief Executive of HMPPS should provide the Ombudsman with a revised date for issuing detailed national guidance on measures to reduce the supply and demand of drugs in prisons, and an assurance that this new date will be met.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Dovegate informing them of the investigation and asking anyone with relevant information to contact him. No prisoners responded.

17. The investigator visited Dovegate on 10 October. He obtained copies of relevant extracts from Mr Watson's prison and medical records.

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

19. The investigator interviewed seven members of staff and two prisoners at Dovegate in November. All the interviews were conducted jointly with the clinical reviewer.

20. We informed HM Coroner for South Staffordshire of the investigation. He gave us the cause of death and toxicology results. We have sent the coroner a copy of this report.

21. The investigator was contacted by Mr Watson's mother on 9 October. He explained the investigation process and asked whether there were any matters she wanted the investigation to consider. Mr Watson's mother wanted to know what treatment her son had received and what medication he had been prescribed and why. She also wanted to know the events surrounding her son's death. Mr Watson's family subsequently obtained legal representation.

22. We have answered Mr Watson's mother's questions in this report. Mr Watson's family received a copy of the draft report. The solicitor representing Mr Watson's family wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Dovegate

23. HMP Dovegate is a Category B prison in Staffordshire run by Serco. The main prison holds around 933 remanded and sentenced adult men. There is also a therapeutic community, separate to the main prison, which holds up to 200 men. Care UK provides 24-hour healthcare services, seven days a week. South Staffordshire and Shropshire Foundation Trust provides mental health services.

HM Inspectorate of Prisons

24. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Dovegate in June 2017. Inspectors found the prison was having to contend with a number of physical and operational security challenges which included confronting organised criminality, mobile phones and drugs.

25. Improvements to the management of intelligence were evident and interventions were beginning to be effective. However, drug testing and contraband finds indicated that the availability of illicit substances, including brewed alcohol and psychoactive substances, was considerable and the prison needed to have a better coordinated response to reducing drug supply. Inspectors found that substance misuse interventions to help reduce demand were, in contrast, excellent.

Independent Monitoring Board

26. 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 last annual report, published in February 2018, the IMB was very concerned about the availability and use of psychoactive substances which caused additional pressures for both nursing staff and officers.

Previous deaths at HMP Dovegate

27. Mr Watson's was the second self-inflicted death at Dovegate since January 2015. In the previous self-inflicted death, we made recommendations about the management of prescribed medication and the emergency response.

Psychoactive Substances (PS)

28. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

29. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt,

bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

30. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Key Events

31. Mr Marlon Watson had a custodial history dating back to 2008. In November 2014, he was convicted of robbery and possession of a firearm. He was released on licence in March 2016.

32. On 17 April 2017, he was recalled into custody at HMP Leicester after being charged with robbery and possession of a firearm. On 27 June, Mr Watson was convicted and sentenced to nine years four months. On 5 October, he transferred from Leicester to HMP Dovegate.

33. Mr Watson had a history of illicit drug use, depression and nocturnal enuresis (bed-wetting).

34. A nurse saw Mr Watson in reception when he arrived at Dovegate. She recorded that Mr Watson had been prescribed sertraline (an antidepressant) while at Leicester, was not allowed to hold medication in his possession and had an outstanding hospital appointment for urinary problems. Mr Watson said he had no thoughts of self-harm or suicide. She recorded that Mr Watson needed to occupy a single cell because of his bed-wetting.

35. On 3 November, staff conducted a routine cell check of Mr Watson's cell and found 20 litres of home-made fermenting liquid, colloquially known as 'hooch'. Staff referred Mr Watson to the substance misuse team.

36. On 8 November, Mr Watson was sent a letter to inform him he had an appointment with a prison doctor on 13 November. Mr Watson did not attend this appointment.

37. On 17 November, a member of the substance misuse team saw Mr Watson as a result of the staff referral. Mr Watson said that he had no issues with either alcohol or illicit drugs and did not wish to engage with substance misuse services.

38. On 23 January 2018, Mr Watson's security records show that intelligence suggested he was involved in the trafficking of drugs both into and within Dovegate. As a result, on 25 January, staff conducted another search of Mr Watson's cell and found five litres of hooch. Staff again referred Mr Watson to the substance misuse team.

39. On 31 January, a member of the substance misuse team saw Mr Watson as a result of the staff referral. Again, Mr Watson said that he had no issues with either alcohol or illicit drugs and did not wish to engage with substance misuse services.

40. On 1 March, staff found Mr Watson apparently under the influence of PS and called for urgent healthcare assistance. A nurse responded and recorded that although Mr Watson was conscious and responsive, he was unsteady on his feet and his speech was slurred. Mr Watson refused any medical intervention or treatment. Mr Watson was again referred to the substance misuse team.

41. On 8 March, a member of the substance misuse team saw Mr Watson following the referral made by a nurse. Mr Watson admitted that he used PS to help with anxiety and depression. He said before he came to Dovegate he had been

prescribed an antidepressant and sleeping medication. The member of the substance misuse team referred Mr Watson to be seen by a doctor.

42. On 1 May, Mr Watson's security records show that intelligence suggested that he was involved in the supply of drugs in Dovegate and was using his partner's bank account to receive payments for drugs.

43. On 3 May, Mr Watson saw a prison doctor. Mr Watson said he slept badly, was agitated and had wet the bed since childhood. Mr Watson also admitted that he used illicit drugs. Mr Watson said he had been prescribed sertraline in the past but this caused him to hear voices. He said he had taken amitriptyline before and found it helped him. Mr Watson said he had no thoughts of suicide or self-harm.

44. The prison doctor completed Patient Health Questionnaire–9 (PHQ-9), a health screening tool to assess depression). The PHQ-9 indicated that Mr Watson had mild to moderate depression. He recorded Mr Watson had a history of using illicit drugs, including PS. He prescribed a 25mg daily dose of amitriptyline (for depression, insomnia and bed wetting) and referred Mr Watson to the urology department at a hospital.

45. On 25 May, staff conducted another cell search of Mr Watson's cell and found five litres of hooch and smoking paraphernalia (which could have been used for illicit drugs). Staff again referred Mr Watson to the substance misuse team.

46. On 31 May, Mr Watson had a follow up appointment with a prison doctor but he did not attend.

47. On 5 June, a member of the substance misuse team saw Mr Watson following the staff referral for his possession of hooch and smoking paraphernalia. Mr Watson said he had no issues with either alcohol or drugs. However, he admitted he had hooch in his cell and said that he was fully aware of the risks of using it. Again, Mr Watson said he did not want any support from the substance misuse team.

48. On 5 July, 14 August and 5 September, Mr Watson had appointments with a prison doctor but he did not attend any of these appointments.

49. On 6 August, Mr Watson was allocated a single cell in the prison's Social Responsibility Unit (SRU). The aim of the unit is that prisoners should work closely with the psychology team to break the cycle of poor behaviour or pattern of breaking prison rules such as drug use.

50. On 6 September, a GP saw Mr Watson to review his medication. Mr Watson said the amitriptyline had helped him but he felt, based on his past experience, that a higher dose would be of greater benefit. The GP agreed to increase his prescription of amitriptyline to 50mg a day.

51. On 11 September, at 9.30am, Mr Watson had an appointment at the urology department at hospital but he refused to attend. At 5.00pm, a nurse saw Mr Watson as he said he had been assaulted by a fellow prisoner. The nurse recorded that Mr Watson had a superficial wound to his left arm which he cleaned with saline solution and dressed. No further treatment was required.

52. Following the incident on 11 September, intelligence was received that Mr Watson had received £500 instead of £50 from another prisoner. The other prisoner wanted the balance of the money returned and assaulted Mr Watson for that reason.

53. Two Prison Custody Officers (PCO), who worked in the SRU, both told the investigator that Mr Watson was a quiet individual who kept himself to himself and gave no indication that he had thoughts of self-harm.

54. A PCO explained that the SRU is on the upper landing of K Wing, and is locked off from the remainder of the wing. The regime on the SRU is different to that on the rest of the wing and prisoners are unlocked from 8.30am onwards. Only one side of the SRU landing is unlocked at a time, with only five prisoners out of their cells at any one time. Prisoners who are on prescribed medication are escorted one at a time to get their medication from the medication hatch and then returned to their cells.

55. A forensic psychologist in training who worked in the SRU, told the investigator that Mr Watson said he had previously run his own business but had turned to crime for financial gain. She said Mr Watson's focus was his children and on his desire to leave prison and provide for them. She said Mr Watson was a quiet man who kept himself to himself. She could not recall him ever associating with one particular prisoner or group of prisoners. She said Mr Watson gave no indication that he had any thoughts of harming himself or of suicide. She said the last time she spoke with Mr Watson was on 26 September.

Events of 26 to 28 September

56. Prisoners' telephone calls on prison phones are recorded and a sample of them are listened to. Mr Watson made a number of calls from 26 to 28 September and the investigator listened to them. Prison staff had not listened to them. It is possible that Mr Watson also made or received calls on an illicit mobile phone during this time.

57. On 26 September, Mr Watson made two telephone calls to his partner, one at 7.59pm, and the other at 8.03pm. The investigator listened to both these calls. Mr Watson sounded cheerful and upbeat and spoke to a young boy. He then had a general conversation with his partner.

58. On 27 September, at 11.19am, Mr Watson called his mother. This phone call lasted two minutes and 21 seconds and the investigator listened to this call. Mr Watson was very angry and agitated. He kept saying that his money had gone into his partner's bank account and that she had stolen it. He said his partner had spent his money and she had a new boyfriend in the house. The call ended without Mr Watson's mother having the opportunity to say anything.

59. On 28 September, Mr Watson called his partner twice, once at 9.58am for one minute and 8 seconds, and again at 10.03am for five minutes and 55 seconds. Again, the investigator listened to both these calls. In both calls, Mr Watson's speech was clearly slurred in comparison to his speech in the calls of the previous two days.

60. In the first call. Mr Watson asked if he would be able to get "that £30". His partner replied, "I've put that £30 in today." In the second call, the conversation revolved around Mr Watson's belief that his partner was in a new relationship. He said he was not going to ring her anymore as he only caused her problems and she had moved on with her life. She replied that he only caused her a problem by asking her to go to the bank all the time. The conversation ended when Mr Watson's partner said, "My life is nothing to do with you, get a fucking grip." Mr Watson replied, "Good luck to ya, good luck with the kids and that, yeah." Mr Watson's partner replied, "You're a fucking joke." Mr Watson said, "Yeah man" and he ended the call.

61. Two fellow prisoners, each told the investigator that Mr Watson preferred his own company and usually kept himself to himself. One of the prisoners said that on 28 September Mr Watson had told him he had fallen out with his partner and this was troubling him. The other prisoner said his cell was next door to Mr Watson's. He said he had spoken to Mr Watson on the evening of 28 September and he appeared fine.

Events of Saturday 29 September

62. At 5.54am, CCTV footage shows a PCO conducting the early morning roll check (a security count to ensure all prisoners are in their cells). There were no concerns regarding Mr Watson.

63. A prisoner told the investigator he thought that he had heard Mr Watson out of bed sometime between 8.30am and 8.45am, and that they had spoken to one another through the gaps in the cell door.

64. At 9.16am, CCTV footage shows a PCO arrived at Mr Watson's cell to unlock his cell to escort him to collect his medication. The PCO told the investigator that when he got to Mr Watson's cell, he noticed that the observation panel in the cell door was covered. He opened the cell door and saw Mr Watson hanging from the light fitting in his cell by a ligature made from what appeared to be prison clothing.

65. The PCO said that Mr Watson had burned two holes into the plastic light fitting and fed the ligature through the holes. The PCO said that Mr Watson was fully dressed.

66. The PCO immediately called another PCO, who was on the wing, to come to the cell. The other PCO immediately radioed a code blue medical emergency, which indicates a prisoner is unable to breathe or having difficulty breathing. One of the PCO cut the ligature and he and the other PCO immediately began cardiopulmonary resuscitation (CPR).

67. The prison control room log shows staff called the code blue emergency over the radio at 9.14am and that an ambulance was called immediately. (This highlights a two-minute discrepancy in the time of the clock in the control room and the timing on the CCTV system.) However, West Midlands Ambulance Service records show that the 999 call was received at 9.21am.

68. CCTV footage shows that two nurses arrived at Mr Watson's cell at 9.19am. Both nurses continued with resuscitation and used an automated external

defibrillator, which administers electrical shocks to restore a normal rhythm to the heart if any is found. The defibrillator found no shockable rhythm, so both nurses continued with CPR.

69. CCTV footage shows that paramedics arrived at 9.35am and took over Mr Watson's care. At this point both PCO's came out of the cell. An air ambulance crew, including a doctor, arrived at 9.40am. They continued with CPR but, after a period of treatment, the doctor pronounced Mr Watson dead at 9.55am.

Post-mortem report

70. HM Coroner for South Staffordshire confirmed no post-mortem was undertaken and that the cause of Mr Watson's death was hanging. The toxicology results showed that Mr Watson had used PS before his death and that it was possible that this had affected his behaviour in the period leading up to his death.

Contact with Mr Watson's family

71. Mr Watson's nominated next of kin was his partner. Two family liaison officers (FLO) from Dovegate, visited Mr Watson's partner at her home address at 12.40pm, to break the news of Mr Watson's death and to offer condolences. In the days that followed, Dovegate maintained contact with Mr Watson's partner and his family and, in line with Prison Service instructions, the prison contributed to the costs of his funeral.

Support for prisoners and staff

72. The Head of Safer Custody, held a debrief for staff involved in the emergency response, including healthcare staff, to ensure they had the opportunity to discuss any issues arising, and for managers to offer support. The staff care team also offered support.

73. The prison posted notices informing staff and prisoners of Mr Watson's 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 Watson's death.

Findings

Management of risk of suicide and self-harm

74. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* which sets out the Prison Service's framework for delivering safer custody procedures, lists a number of risk factors and potential triggers for suicide and self-harm. These include a prisoner's first time in custody, recall to custody, early days in custody, previous self-harm, being charged with a violent offence, a history of alcohol or drug abuse and court appearances, especially at the start of a trial and sentencing. Staff should interview new prisoners in reception to assess their risk of suicide or self-harm. All staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns, including opening suicide and self-harm prevention procedures (known as ACCT) if necessary.

75. Mr Watson had no recorded history of self-harm or attempted suicide. We are satisfied that staff at Dovegate had no reason to consider that he presented a risk to himself. It appears that Mr Watson believed that his relationship with his partner had ended but this was not known to prison staff.

76. Toxicology results show that Mr Watson was under the influence of PS at the time of his death and it is possible that this affected his behaviour.

Psychoactive Substances

77. Mr Watson's security records show that he had had a history of PS use and associated debt since 2014. After his arrival at Dovegate in October 2017, Mr Watson's security records show that he said he used drugs and was found to have hooch, smoking paraphernalia and a mobile phone in his cell. There was also intelligence that Mr Watson was involved in the trafficking of drugs into Dovegate and that his partner's bank account was used to receive payments for the supply and purchase of drugs.

78. Staff acted on the intelligence received, and targeted cell searches were appropriately conducted. Mr Watson lived in the SRU with the supposed intention of working with staff to address his use of illicit substances. He was repeatedly referred to substance misuse services for help and support, but he chose not to engage with them.

79. Apart from the incident on 11 September, the investigator found no other intelligence or evidence to indicate that Mr Watson was being bullied.

80. Toxicology results show that Mr Watson used PS immediately before his death. Reported side-effects of PS include mood swings, anxiety, paranoia and suicidal thoughts. It is therefore possible that Mr Watson's actions were influenced directly by PS use.

81. We are concerned that Mr Watson was able to obtain PS while in Dovegate. We note that both HM Inspectorate of Prisons and the Independent Monitoring Board

have expressed concern about the ready availability of drugs at Dovegate and it is obviously a cause for concern that Mr Watson could obtain and use them.

82. Dovegate is not alone in facing this problem –the availability of drugs, including PS, is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, in the PPO's view there is now an urgent need for national guidance to prisons from HMPPS providing evidence-based advice on what works.

83. In a previous investigation, we recommended that the Chief Executive of HM Prison and Probation Service (HMPPS) should issue detailed national guidance on measures to reduce the supply and demand of drugs, including PS, in prisons. The Acting Ombudsman also wrote to the Prisons Minister raising her concerns about the high number of drug-related deaths she was investigating. The Chief Executive told us in response that HMPPS planned to issue a national drug strategy in the autumn of 2018. We are concerned that at the time of writing (March2019), this strategy has still not been issued. We therefore repeat the following recommendation:

The Chief Executive of HMPPS should provide the Ombudsman with a revised date for issuing detailed national guidance on measures to reduce the supply and demand of drugs in prisons, and an assurance that this new date will be met.

Clinical care

84. The clinical reviewer, judged that the care that Mr Watson received from healthcare staff at Dovegate was equivalent to the care he would have received in the community.

85. The clinical reviewer commented that Mr Watson had access to the healthcare services he required, was referred to a specialist for his bed-wetting problems, and was repeatedly offered assistance and support from the substance misuse team, which he chose not to engage with. He also repeatedly failed to attend appointments with the GP.

Emergency response

86. PSI 03/2013, *Medical emergency response codes,* says that governors must have a medical emergency response code protocol to ensure that prisons call an ambulance immediately in a life-threatening medical emergency. The PSI explicitly states that control room staff should automatically call an ambulance whenever an emergency code is called and that it is not necessary for a member of the prison healthcare team or a duty manager to attend the scene before emergency services are called.

87. From the time that a PCO found Mr Watson hanging and the other PCO called an emergency code at 9.16am, there was a delay of five minutes before an ambulance was called. Ambulance Service records show that the 999 call was received at 9.21am.

88. While this did not affect the outcome for Mr Watson it could be crucial in other emergencies. We make the following recommendation:

The Director should ensure that control room staff call an ambulance as soon as an emergency code is broadcast.

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