Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ian McGregor a prisoner at HMP Hull on 12 May 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 I 020 7633 4100
F I 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*

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 Ian McGregor died on 12 May 2018 of bilateral pneumonia at HMP Hull. He was 72 years old. I offer my condolences to his family and friends.

Mr McGregor had a number of pre-existing health conditions. Although he received appropriate and responsive care for the most part, his care overall was not equivalent to that which he could have expected to receive in the community. Staff only assessed Mr McGregor's risk of a fall after he had had a fall, and his deteriorating condition was not monitored as closely as it should have been on the night before his death.

I am concerned that despite Mr McGregor's poor health and restricted mobility, he was inappropriately restrained when he visited hospital for an appointment and that staff did not appear aware of caselaw which sets out the factors they should consider when deciding on the use of restraints. As this is the third time we have identified this as an issue at Hull, I have escalated my concerns to the Prison Group Director for Yorkshire.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **November 2018**

Contents

Summary

Events

1. On 26 April 2017, Mr Ian McGregor was sentenced to three years in prison for sexual offences, and sent to HMP Hull.

2. Mr McGregor had many health problems and often attended the healthcare department.

3. On 13 February 2018, Mr McGregor had a stroke. When he returned from hospital on 20 February he was located in his cell on a standard wing, but a falls risk assessment was not completed as it should have been. Mr McGregor fell that night and broke his hip. He was taken to hospital and had his hip replaced on 22 February.

4. Mr McGregor's health deteriorated, and on 20 April a GP referred him for tests for possible gastrointestinal cancer. On 25 April, he was prescribed antibiotics and moved to the Wellbeing Unit (used for prisoners with a range of complex medical needs) to be monitored.

5. On the night of 11/12 May, a nurse saw Mr McGregor four times between 8.00pm and 7.00am. She observed that Mr McGregor was unwell – he initially appeared to be in pain, his breathing was poor, he was confused and he could not speak – but she did not check his vital signs or increase the level of clinical observations.

6. At 7.45am on 12 May, prison officers found him unresponsive. An officer radioed for medical assistance and the control room called for an ambulance 13 minutes later. Healthcare staff and a paramedic tried to resuscitate him. Ambulance staff arrived at 8.04am and Mr McGregor was confirmed dead at 8.07am.

Findings

Clinical care

7. The clinical reviewer considered that while the healthcare team were mostly responsive to Mr McGregor's needs, the care that Mr McGregor received at Hull was not equivalent overall to that which he could have expected to receive in the community.

8. The clinical reviewer considered that a falls risk assessment should have been completed when Mr McGregor came back from hospital to Hull after having a stroke.

9. The clinical reviewer found that healthcare staff should have monitored Mr McGregor more closely on the night of 11/12 May 2018 to identify and address his deteriorating health.

Restraints

10. A prison manager authorised the use of restraints despite Mr McGregor having limited mobility and being in poor health. We consider that when staff assessed Mr McGregor's security risk before he left Hull for his hospital appointment, they

did so using a blanket approach which did not consider the impact of his poor health and limited mobility or his already low risk of escape, as they should have, and as a consequence the use of mechanical restraints was disproportionate and unnecessary. As the prison has previously committed to implement measures to address the inappropriate use of restraints, we now escalate our concerns.

Emergency response

11. There were deficiencies in the emergency response: staff should have radioed an emergency code immediately after Mr McGregor was found unresponsive and there was a delay of 13 minutes before the control room called for an ambulance. While we cannot say whether this might have affected the outcome for Mr McGregor, such a delay might be critical in another emergency.

Recommendations

- **The Head of Healthcare should ensure that healthcare staff offer all older prisoners at risk of falls a thorough risk assessment in line with guidance from the National Institute of Clinical Excellence (NICE).**
- **The Head of Healthcare should ensure that staff respond appropriately to a patient whose health is deteriorating, and use the National Early Warning Score (NEWS) system to assess prisoners effectively.**
- **The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on restraining prisoners and that assessments fully take in to account the health of a prisoner and are based on the actual risk he presents at the time.**
- **The Prison Group Director, Yorkshire, should assure himself that effective steps are taken to stop the inappropriate use of restraints for hospital escorts.**
- **The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies to ensure that staff:**
    - **Communicate the nature of a medical emergency efficiently and effectively; and**
    - **Call for an ambulance immediately after an emergency code message is radioed.**

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Hull informing them of the investigation and asking anyone with relevant information to contact her. A prisoner wrote to the investigator and she interviewed him.

13. The investigator visited HMP Hull on 23 May. She obtained copies of relevant extracts from Mr McGregor's prison and medical records.

14. The investigator interviewed one member of staff by telephone on 11 June 2018 and seven members of staff in person at HMP Hull on 19 June 2018.

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

16. The clinical reviewer interviewed two members of staff by telephone on 18 June 2018 and joined the investigator for interviews at Hull on 19 June.

17. We informed HM Coroner for Hull of the investigation who gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

18. Ms Laing wrote to Mr McGregor's daughter to explain the investigation. She did not respond.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Hull

20. HMP Hull is a medium security prison in Yorkshire that holds over 1,000 prisoners. Healthcare is provided by City Healthcare Partnership. The prison closed its inpatient healthcare unit in October 2014. It became a Wellbeing Unit, with a specialist palliative care cell fit for two prisoners and four cells for those who need additional care. The prison has two on-site paramedics.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Hull was in April 2018. Inspectors found that health provision was reasonable and governance was mostly effective, but some health services had deteriorated since the last inspection. The team offered an appropriate range of primary care clinics, within an acceptable timeframe. Social care assessments were timely and the provision was reasonably good.

Independent Monitoring Board

22. 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 2015, the IMB reported that Hull was an effectively run prison that provided a safe and decent environment.

Previous deaths at HMP Hull

23. Mr McGregor was the thirteenth prisoner to die at HMP Hull since June 2015, and the tenth from natural causes. Since June 2015, we have twice identified (before this case) the inappropriate use of restraints. We have also previously made a recommendation about the need for staff to identify and manage a prisoner's deteriorating condition.

Key Events

24. On 26 April 2017, Mr Ian McGregor was sentenced to three years in prison for sexual offences. He was sent to HMP Hull.

25. Mr McGregor had a number of chronic health conditions, including Type 2 diabetes, ischaemic heart disease, angina, asthma, chronic obstructive pulmonary disease (COPD), rheumatoid arthritis and iron deficiency anaemia. He was prescribed medication to manage these conditions.

26. On 26 April, a nurse completed a first night reception screening for Mr McGregor and noted his medical history. He assessed that Mr McGregor was suitable to be located on a standard wing.

27. On 27 April, a nurse completed a second health screening. Mr McGregor reported a history of low mood and depression and was referred to the mental health team but was assessed as not in need of the service.

28. Mr McGregor often attended the healthcare department for his many health needs. His attendance increased from November 2017.

29. On 11 November, Mr McGregor told wing staff that he felt unwell, was cold and had been coughing up green mucus. A nurse decided that he should go to hospital.

30. That day, Mr McGregor went to hospital and was treated for a worsening of chronic obstructive pulmonary disease (a lung condition that causes breathing difficulties) as the result of an infection. He was scheduled to have a chest x-ray in six to eight weeks to check if the infection had cleared up. He returned to Hull on 15 November.

31. On 27 November, a prison GP saw Mr McGregor at Hull as he had a sore throat and had lost his voice. Mr McGregor had lost weight and his bowel habits had changed. The GP referred Mr McGregor urgently to the Colorectal Team at the hospital for suspected bowel cancer.

32. On 14 December, Mr McGregor saw a consultant colorectal surgeon at the hospital, who referred him for a CT scan (a scan that uses x-rays and a computer to create detailed images of the inside of the body).

2018

33. On 12 January 2018, Mr McGregor had a chest x-ray. The condition of his lungs had improved and he was told that if he had symptoms in the future, he should have another scan.

34. On 26 January, the colorectal team wrote to the prison to say that Mr McGregor's CT scan showed that he had a chest infection (that was already being treated). They said that they were still waiting for the results of a colonoscopy (an examination to look at the lining of the large bowel) and endoscopy (an examination to look at the food pipe, stomach and first part of the bowel) that

took place in the community in 2016. They also said that if they showed no issues, no more tests for bowel cancer would be needed.

35. On 13 February, Mr McGregor's cellmate alerted staff that Mr McGregor was not feeling well. A nurse attended and assessed that Mr McGregor needed to go to hospital. He was transferred to hospital, where a scan showed that Mr McGregor had had a small stroke.

36. A nurse assessed Mr McGregor when he returned to Hull on 20 February and reviewed the hospital discharge summary, which included a handwritten note saying that Mr McGregor's balance was impaired. The nurse said that the discharge summary did not indicate that Mr McGregor needed extra support. The nurse assessed that Mr McGregor was fit to live on a standard wing.

37. At 2.30am on 21 February, Mr McGregor slipped on his cell floor. His cellmate alerted staff. An operational support grade contacted the custodial manager, who attended with a nurse.

38. The nurse said that Mr McGregor was lying on the floor when she arrived. His right elbow and hip hurt and he had been incontinent. Officers helped Mr McGregor onto the bed. The nurse applied an adhesive strip to his elbow as he had scraped it. She examined his hip, found no injury and assessed his vital signs as satisfactory. Prison staff helped Mr McGregor change in to clean clothes and got him back in bed. The nurse said that he declined paracetamol for pain relief. Mr McGregor's cellmate agreed to tell staff if there were any problems during the night. The nurse said that she also asked wing staff to observe him closely and that she completed a falls risk assessment.

39. Later that morning, two nurses asked a prison paramedic to see Mr McGregor. The paramedic said that he arrived at Mr McGregor's cell between 9.00m and 10.00am. He thought that Mr McGregor had fractured his hip and called for an ambulance. Mr McGregor went to hospital, where he was diagnosed with a broken hip. He had his right hip replaced the next day.

40. On 23 February, the hospital wrote to the prison to say that a CT scan had been booked for three months' time to make sure that Mr McGregor no longer had pneumonia (swelling of tissue in the lungs caused by an infection). Their records showed that the colonoscopy and endoscopy completed in 2016 were normal.

41. On 1 March, Mr McGregor returned to Hull, where a nurse assessed that he was not fit for a cell on a standard wing. He was therefore moved to the Wellbeing Unit.

42. On 15 March, healthcare staff ordered a self-propelled wheelchair, chair raiser and a wheeled walking frame for Mr McGregor. On 1 April, having received mobility aids, Mr McGregor returned to his usual cell on a standard wing. It was also agreed that healthcare staff would visit him daily to make sure that his needs were being met.

43. On 11 April, a 'care buddy' (a prisoner who looks after another prisoner) moved in to Mr McGregor's cell to help him with daily living tasks such as cleaning his cell and getting his meals.

44. On 16 April, Mr McGregor had another CT scan at the hospital. Two prison officers took him to hospital, restrained with single handcuffs. (Hull did not receive the results of the CT scan before he died.)

45. On 18 April, a healthcare assistant saw Mr McGregor for a welfare check. He told her that he had coughed up blood, a sample of which was sent to a laboratory for testing on 19 April.

46. A health promotion advisor from the prison weight management service, met Mr McGregor on 18 April. It is not clear from clinical records who referred him or when Mr McGregor's weight loss became a concern. He made sure that Mr McGregor knew it was important to have a high-calorie diet and high-protein supplements were prescribed.

47. A healthcare assistant saw Mr McGregor on 19 April. She recorded that his condition had deteriorated. She noted that he often coughed up blood and had no energy. She noted that a sample had been sent for testing, that she had taken his observations and concluded that his level of care did not need to be increased.

48. A prison GP examined Mr McGregor on 20 April. She noted that Mr McGregor had lost 19.35 kilograms in weight since February 2018 and that his iron deficiency anaemia had got worse. She referred Mr McGregor under the two-week cancer pathway, for tests for suspected gastrointestinal cancer. She noted that Mr McGregor had asthma, had been coughing up blood-stained sputum and lacked energy.

49. On 25 April, Mr McGregor was transferred to the Wellbeing Unit to be monitored more closely and he remained unwell over the following days. The sample sent for testing showed that he had an infection and on 25 April a prison GP rescribed antibiotics. Mr McGregor's condition then improved.

50. A consultant upper gastrointestinal surgeon at the hospital saw Mr McGregor on 26 April (following the urgent referral on 20 April). He referred him for a colonoscopy and endoscopy which were arranged for 14 May. (Mr McGregor died two days before this.)

51. On 9 May, a healthcare assistant assessed that Mr McGregor had a mild risk of developing bedsores. An airflow mattress and bed was ordered but he died before they arrived.

12 May

52. The nurse on duty overnight from 11 to 12 May checked on Mr McGregor at approximately 8.00pm and noted that he was difficult to understand. He appeared to be in pain but was not able to say where his pain was. He appeared to be uncomfortable when he was touched and had pale skin. She did not think that it was necessary to complete clinical observations or increase how often he was seen overnight.

53. The nurse observed Mr McGregor again at 1.35am on 12 May. He appeared to be asleep, moved his left hand and seemed settled.

54. The nurse saw Mr McGregor at 5.45am, by which time his condition had declined. He did not appear to know where he was and was unable to speak. She did not take his clinical observations but said she remembered checking his oxygen saturation levels. She believed that his reading was 91% to 92% (normal readings usually range from 95% to 100%). This was not noted in the clinical records.

55. The nurse saw Mr McGregor again at 6.57am. She described his breathing as "poor". She did not complete any clinical observations, but again said she recalled checking his oxygen saturation levels. She believed that they were between 91% to 92%. These observations were also not noted in the clinical records.

56. The nurse said that at the end of her shift, she told day staff that Mr McGregor was unwell. This is not recorded in his clinical records.

57. A nurse saw Mr McGregor at 7.13am. She said that he appeared to be asleep in bed, there were breathing movements and she had no concerns.

58. A Supervising Officer (SO) said that he came on duty at around 7.40am. He looked in to Mr McGregor's cell and saw that he looked vacant and was not moving.

59. The SO shouted to an officer, who was by Mr McGregor's cell door, to alert the communications room and healthcare staff that immediate assistance and an ambulance was required. At 7.43am, the officer radioed for assistance. An operational support grade contacted the officer from the communications room to ask if an ambulance was needed. She said that the officer said he would let her know, and that at 7.56am she was told to call for an ambulance, which she did.

60. A senior nurse heard the radio alert and immediately collected the emergency bag and went to the Wellbeing Unit with another senior nurse. She told us that this took two minutes as the Nursing Hub was close by.

61. The senior nurse told us that Mr McGregor was on his bed. He had no pulse, was not breathing, had no chest movements but was warm to the touch. She requested that a prison paramedic attend immediately.

    The senior nurse started cardiopulmonary resuscitation (CPR). Another nurse applied a defibrillator (a device that gives a high-energy electric shock to the heart), which advised not to shock Mr McGregor but to continue doing chest compressions. Staff moved Mr McGregor to the floor, and healthcare staff continued chest compressions. When the paramedic arrived, he inserted an airway and gave Mr McGregor two breaths.

62. Paramedics were with Mr McGregor at 8.04am. They noted that he had some stiffening, his pupils were fixed and dilated and his skin was discoloured from poor blood circulation. CPR was stopped, and the prison paramedic confirmed Mr McGregor's death at 8.07am.

Contact with Mr McGregor's family

63. Mr McGregor's next of kin was his daughter, who lived approximately sixty miles away from the prison. Mr McGregor had lost contact with her in late December 2017. He told prison staff that he did not know why she did not want contact with him.

64. The prison appointed a family liaison officer (FLO) on 14 February 2018 after Mr McGregor had a stroke. She was unable to contact his next of kin by telephone. On 15 February, she wrote to his daughter to say that her father had had a stroke and to give her the opportunity to visit him in hospital. She did not respond. The FLO was unable to contact her. She kept Mr McGregor informed of her attempts to contact his family.

65. The FLO was on annual leave when Mr McGregor died on 12 May. Another FLO was on the Wellbeing Unit when he died. She told a prison manager that it had not been possible to contact Mr McGregor's next of kin in February. At 12.10pm, the manager asked the police to go to Mr McGregor's daughter's last known address to break the news to her. The police later confirmed that they had informed Mr McGregor's sixteen-year-old grandson, who had found it upsetting. They did not know if the family wanted the prison to contact them.

66. A senior manager telephoned the first FLO at home on 13 May to tell her that Mr McGregor had died. The FLO visited Mr McGregor's daughter with a prison manager that afternoon, and they offered their condolences and support. Hull arranged and contributed to the costs of Mr McGregor's funeral, in line with national instructions.

Support for prisoners and staff

67. After Mr McGregor's death, a prison manager debriefed staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising and to offer support. The staff care team also offered support.

68. The prison posted notices informing other prisoners of Mr McGregor'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 McGregor's death.

Post-mortem report

69. The post-mortem report established that Mr McGregor died from bilateral pneumonia.

Findings

Clinical care

70. The clinical reviewer found that Mr McGregor mostly received appropriate and responsive care. Staff met his specialist needs and maintained his comfort. The clinical reviewer also considered the emergency response by healthcare staff was appropriate. However, she considered that the care that Mr McGregor received at Hull was not equivalent to that which he could have expected to receive in the community. She was concerned that a risk of falls assessment was only completed after he had a fall and that there were deficiencies in identifying Mr McGregor's deteriorating health.

71. The clinical reviewer made a number of recommendations in her report which the Head of Healthcare will need to address.

Risk of falls

72. On 20 February, Mr McGregor returned to prison after a stroke. A nurse assessed him in reception and returned him to his cell on a standard wing. The hospital discharge summary said that Mr McGregor's balance was impaired and supported a falls risk assessment being completed but the nurse did not consider completing one. Mr McGregor had a fall and fractured his hip in the early hours of 21 February.

73. The Head of Healthcare said that only prisoners at Hull who have had a fall would have an assessment. She said that it was not routine for older people to be assessed before they had a fall. The clinical reviewer considered that a falls risk assessment should have been completed. It might not have prevented Mr McGregor from falling but would have highlighted his risk factors. We recommend that:

The Head of Healthcare should ensure that healthcare staff offer all older prisoners at risk of falls a thorough risk assessment in line with guidance from the National Institute of Clinical Excellence (NICE).

Recognising a deteriorating patient

74. A nurse observed Mr McGregor overnight from 11 to 12 May. She noted that his condition had deteriorated and said she recalled that she checked his oxygen saturation levels, although this was not recorded. She said that as his levels were satisfactory, she did not complete a full set of clinical observations and did not use the National Early Warning Score (NEWS) tool (which is designed to help clinicians respond to a deterioration in health). She said that she had been aware of NEWS and, with hindsight, she should have completed a set of clinical observations.

75. The clinical reviewer considered that by monitoring changes in Mr McGregor's physiological observations on the night of 12 May 2018, any signs of a deterioration in his condition could have been identified and addressed. The nurse should also have used the NEWS tool. We make the following recommendation:

The Head of Healthcare should ensure that staff respond appropriately to a patient whose health is deteriorating, and use the National Early Warning Score (NEWS) system to assess prisoners effectively.

Restraints

76. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes in to account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

77. Mr McGregor was restrained when he was taken to hospital for a scan on 16 April 2018. There were no medical objections to the use of restraints in the escort risk assessment. A nurse recorded that Mr McGregor had restricted movement and used a wheelchair but was fit to travel. A custodial manager noted that Mr McGregor posed a low level of risk to the public, of hostage taking, of potential to escape and of external assistance. Despite this, a prison manager concluded that two officers should escort Mr McGregor and use a single-cuff restraint (which meant that he was handcuffed by one arm to an officer). She approved the use of an escort chain (a handcuff on the end of a chain) if he was in his wheelchair.

78. The prison manager told the investigator that she had never met Mr McGregor but knew that he had been supervised by a prison officer while in hospital. She said that she approved the use of restraints as it was standard practice to use a single cuff for Category C prisoners outside prison. She said that she added the comment to the risk assessment that an escort chain could be used if he was in a wheelchair as she did not know if Mr McGregor used a wheelchair all the time or only to attend hospital visits.

79. The prison manager said that the only consideration she gave to his medical condition was that he had been supervised by prison officers while in hospital and used a wheelchair. She said that she was not aware that Mr McGregor had previously been escorted without restraints. She said that the custodial manger should have noted this on the assessment document before she reviewed it.

80. We are concerned that this apparent blanket approach is inconsistent with the provisions of the High Court judgement and with basic principles of dignity. The Prison Service has a responsibility to protect the public but security must be balanced with humanity. It is difficult to understand how restraints could be considered necessary for an elderly and infirm man with limited mobility who was escorted by two prison officers. Too much weight was given to his original offences without considering his actual risk at the time. This is the third investigation since 2015 in which we have identified concerns about the use of restraints at Hull. Given each time we have made this finding the prison has

agreed to implement our recommendation, we not only repeat that recommendation but also escalate our concern to the Prison Group Director. We recommend that:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take in to account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Prison Group Director, Yorkshire, should assure himself that effective steps are taken to stop the inappropriate use of restraints for hospital escorts.

Emergency response

81. Prison Service Instruction (PSI) 03/2013 on medical emergency response codes says that an emergency code should be called in a medical emergency. It says that if a code blue is called (indicating that a prisoner is unconscious, choking, fitting or concussed, has difficulty breathing, chest pain, a severe allergic reaction or suspected of having a stroke), an ambulance should be called immediately. Hull's local instructions also set out these requirements.

82. On 12 May, a SO found Mr McGregor unresponsive and shouted to an officer to call for immediate emergency assistance and an ambulance. The officer radioed for healthcare assistance, but did not call an emergency code blue. The communications room contacted him to see if an ambulance was needed, which he had to check. This caused a delay of 13 minutes before an ambulance was called.

83. If the SO had called an emergency code immediately, the communication room would have called for an ambulance. It is unlikely to have changed the outcome for Mr McGregor, but radioing an emergency code might be critical in other cases. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies to ensure that staff:

- **Communicate the nature of a medical emergency efficiently and effectively; and**
- **Call for an ambulance immediately after an emergency code message is radioed.**

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141