

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Corin Bonaparte a prisoner at HMP Dartmoor on 28 February 2017

**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.

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

Mr Corin Bonaparte was found hanging in his cell at HMP Dartmoor and died in hospital. He was 23 years old. I offer my condolences to Mr Bonaparte's family and friends.

It was Mr Bonaparte's first time in custody. While there were no obvious signs to indicate outwardly that Mr Bonaparte was at risk of suicide, his healthcare records, to which prison officers did not have access, showed that he had experienced low mood, thoughts of self-harm and was worried that his girlfriend would end their relationship. The investigation identified a number of concerns about the management of Mr Bonaparte's risk at Dartmoor. Prison Service suicide and self-harm prevention procedures were not initiated to protect him. Staff relied too much on his presentation rather than his known underlying risk factors for suicide.

We are concerned that some prison officers at Dartmoor believe radioed emergency codes are only relevant for healthcare staff and they do not need to respond. This is misleading and potentially dangerous. Deviating from local and national policy can cause confusion and delay, as this case sadly demonstrates.

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

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

**March 2018**

## **Contents**

Summary .....	1
The Investigation Process .....	3
Background Information .....	4
Key Events .....	6
Findings.....	11

# Summary

## Events

1. On 18 November 2016, Mr Corin Bonaparte was sentenced to three years and four months in prison for drug offences. It was his first time in custody. He was remanded into custody and was sent to HMP Exeter.
2. At an initial health screen, Mr Bonaparte said he did not have any thoughts of suicide or self-harm. He was transferred to HMP Dartmoor on 13 January 2017.
3. At Dartmoor, he told a nurse that he had a history of depression and anxiety but he did not have thoughts of self-harm or suicide. She referred him to the mental health team for review. He saw a mental health nurse on 17 January and told her that although he had current thoughts of self-harm, he would not act on them. He identified his girlfriend as a protective factor and told staff he was happy to be at Dartmoor as it was closer to his home.
4. On 25 January, Mr Bonaparte's girlfriend emailed him to say that although she would continue to be supportive, she found his behaviour sometimes difficult and was unable to give him the constant reassurance he was seeking. Staff did not read the email.
5. Mr Bonaparte asked a supervising officer if he could see a member of the mental health team on 27 January. In a meeting with a mental health team support worker, he spoke of his fears that his girlfriend, who he described as the only good thing in his life, would finish their relationship. He was very tearful and appeared to be low in mood. Though he denied having any thoughts of self-harm, he said he had been punching himself on the side of his head. The support team worker asked an officer to join the meeting. It was decided not to initiate formal suicide and self-harm procedures at that time as Mr Bonaparte had no active thoughts of suicide and self-harm.
6. A GP prescribed anti-depressants on 31 January and arranged to see Mr Bonaparte again on 21 February, when he increased his medication dosage. Mr Bonaparte had three sessions during February with an assistant psychologist. He told her that he had split up with his girlfriend.
7. On 28 February, Mr Bonaparte returned from work and spoke to his former girlfriend on the telephone. When he did not collect his evening meal and staff could not find him, a prisoner went into his cell at about 5.30pm and found him hanging. The prisoner raised the alarm and officers responded quickly. Staff and paramedics tried to resuscitate Mr Bonaparte but he did not recover consciousness. He was taken to hospital but was pronounced dead at 8.22pm.

## Findings

8. Mr Bonaparte did not tell staff at Exeter of his history of depression and anxiety but disclosed this to healthcare staff when he moved to Dartmoor. While staff demonstrated good practice by arranging a prompt mental health assessment and psychological support, we are not satisfied that Dartmoor fully recognised that Mr Bonaparte's risk was increasing. He was only 23 years old and it was

his first time in custody, having served only two months of his sentence. He disclosed to a nurse that he had a history of depression and anxiety, had also disclosed some self-harming behaviours and said that he was feeling depressed and was clearly struggling with the breakdown of his relationship. Staff did not initiate ACCT suicide and self-harm procedures or alert residential unit officers to his risk so that they could have exercised increased vigilance.

9. The officer who found Mr Bonaparte did not use a recognised emergency code. We are concerned that local practice at Dartmoor is not in line with local and national policy. This meant that the incident manager did not know initially the nature of the incident he was responding to and the control room delayed calling an ambulance as it was not clear that one was needed.

## Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular they should ensure that:
  - staff understand the procedures for identifying, managing and supporting prisoners at risk of suicide and self-harm;
  - staff assess the risk of suicide and self-harm based on all available information and known risk factors and not on a prisoner's own presentation; and
  - staff understand the need to share all relevant information about risk.
- The Governor should ensure that all prison staff are aware of and understand PSI 03/2013 and their responsibilities during a medical emergency, including efficient communication of the nature of the emergency and ensuring there are no delays in calling an emergency ambulance.

## The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Dartmoor informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator visited Dartmoor in March, April and June 2017. She obtained copies of relevant extracts from Mr Bonaparte's prison and medical records.
12. The investigator interviewed 16 members of staff and 3 prisoners at the prison in March, April and June 2017. NHS England commissioned a clinical reviewer to review Mr Bonaparte's clinical care at the prison. They carried out eight joint interviews.
13. We informed HM Coroner for Exeter and Greater Devon of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Bonaparte's parents, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. His father said he would like the issue of risk management to be examined. He felt that Dartmoor had failed in their duty of care, as they had been aware it was his son's first time in custody and that he had said he was depressed, which should have been seen as risk factors. His father said the prison should have watched him more closely as they had referred him for psychiatric or psychological help and increased his prescribed medication. They were concerned that healthcare staff did not go to Mr Bonaparte's cell until an emergency code was radioed.
15. Mr Bonaparte's parents received a copy of the initial report. They pointed out some factual inaccuracies and this report has been amended accordingly. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

# Background Information

## HMP Dartmoor

16. HMP Dartmoor holds up to 659 adult male prisoners. It has six residential wings, known in Dartmoor as ‘tors’. East Tor was known as the resettlement unit (RSU) and housed trusted prisoners who could be released on temporary licence (ROTL) and who worked in the community. Since 2015, ROTL has been curtailed due to regime changes. The unit holds up to 49 selected prisoners and offers a more relaxed atmosphere, enhanced facilities such as its own gym and larger cells. At the time of Mr Bonaparte’s death, healthcare services were provided by Dorset Healthcare University NHS Foundation Trust. Since April 2017, primary healthcare has been provided by Care UK and mental healthcare by Devon Partnership Trust.

## HM Inspectorate of Prisons

17. The last inspection at HMP Dartmoor was in August 2017. Inspectors reported that care for men at risk of suicide and self-harm was reasonably good as was access to Listeners (prisoners trained by the Samaritans). They found staff-prisoner relationships mostly positive and courteous and staff showed a good level of knowledge of individual prisoners. They noted that the level of self-harm was higher than they would expect but acknowledged that a small number of prisoners accounted for many of the incidents. Healthcare inspectors found that the integration of clinical and psychosocial services had improved and there was better joint working with mental health staff.

## 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 2017, the IMB reported that there were good staff-prisoner relationships even though fewer staff meant they often worked under extremely difficult and challenging circumstances. The IMB also reported that Dartmoor’s self-harm rate had increased.

## Previous deaths at HMP Dartmoor

19. This is the third apparently self-inflicted death at Dartmoor since 2004. There are similarities with a previous death in March 2015 of a young man. Staff in that case did not follow the correct emergency response procedures and there was a delay in calling an ambulance. We have repeated our recommendation about emergency response in this investigation. HM Inspectorate of Prisons most recent report noted that there was a good focus on recommendations arising from PPO investigations and that Dartmoor was monitoring and reviewing its progress in completing the relevant action plans.

## Assessment, Care in Custody and Teamwork

20. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT

process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm.

## Key Events

21. On 18 November 2016, Mr Corin Bonaparte was sentenced to three years and four months in prison for drug offences. It was his first time in custody. He was remanded into custody and was sent to HMP Exeter.
22. On arrival at Exeter, an officer explained the support available to Mr Bonaparte and completed a first night immediate risk assessment. He told her that he did not have a history of self-harm and had no current thoughts of suicide or self-harm. She wrote in his computerised record (NOMIS) that she had considered his risk and that he did not need the support of ACCT procedures.
23. A nurse interviewed Mr Bonaparte as part of an initial health check. Mr Bonaparte told him he did not have thoughts of suicide and self-harm.
24. Mr Bonaparte was moved to HMP Dartmoor on 13 January. It was a lower security prison and nearer to his home. A nurse checked his physical health and asked him if he had had any mental health issues such as depression and anxiety. He said that he had but did not elaborate. She asked whether he would like to be referred to the mental health team and he said he would. She made the referral and wrote in his clinical record that he appeared well mentally and had no thoughts of deliberate self-harm.
25. On 17 January, a nurse from the mental health team met Mr Bonaparte for a risk assessment. She noted that he told her he had thoughts of self-harm and it was his first time in prison, which she considered to be risk factors. Mr Bonaparte identified his girlfriend as a protective factor and spoke about learning a trade so that he could get a job on his release. She asked him whether he had current thoughts or plans to self-harm. He said that he did but “won’t act on it”. He said he had had mental health difficulties since he was 17 and had thoughts of suicide since he was young but had been unable to get treatment, support or a formal diagnosis. He described obsessive-compulsive behaviour and said he had negative thoughts he was unable to control. He had harmed himself about a month previously by punching himself in the face and cutting his head with his nails to cope with his situation.
26. The nurse checked the severity of his symptoms using two approved questionnaires, PHQ-9 and GAD, which indicated moderate levels of depression. On 23 January, the mental health team discussed his case and decided to add him to the waiting list for an initial assessment with an assistant psychologist.
27. On 25 January, Mr Bonaparte’s girlfriend emailed him using the facility emailprisoner.com (which allows prisoners to keep in touch with approved family members and friends via email). She told him that while she would remain supportive, she found his behaviour sometimes difficult and was unable to provide him with the constant reassurance he sought from her. The emails are printed out but not routinely read by staff unless specific restrictions have been put in place. No such restrictions were in place for Mr Bonaparte.
28. On 27 January, a supervising officer (SO) was covering a shift on East Tor, Mr Bonaparte’s residential unit, for the morning. Mr Bonaparte asked him whether

he would ask someone from the mental health team to see him. The SO asked if he was alright and Mr Bonaparte said that he was. The SO noted the conversation in Mr Bonaparte's computerised records and told the mental health team office of his request.

29. A mental health support worker visited Mr Bonaparte on East Tor that afternoon. Despite his good eye contact and open body posture, Mr Bonaparte was very tearful, anxious, and low in mood. He shared his concerns that his girlfriend was going to end their relationship and said that she was 'the only good thing in his life' at that time. Mr Bonaparte said he had no active thoughts of deliberate self-harm but he had been punching the side of his head. The mental health support worker noted in his clinical record that she asked an officer, an experienced member of staff who worked on East Tor, to join the meeting so that Mr Bonaparte could discuss his concerns and that the residential unit staff would be aware of his mood. She noted that they discussed ACCT and felt this was not necessary at that time but, if they thought he was at risk or had concerns, staff would initiate ACCT procedures to support him. She noted that Mr Bonaparte was afraid of other prisoners knowing he was on an ACCT and looked shocked when she and the officer mentioned ACCT.
30. The investigator asked the mental health support worker why she decided not to begin ACCT procedures at that time. She said that Mr Bonaparte had no active current thoughts of suicide, he thought things would work out with his girlfriend and even though he was feeling up and down, he had a positive outlook, East Tor staff were supportive and other measures such as the Samaritans and Listeners (prisoners trained by the Samaritans as peer support) could be put in place. She said that the officer 'would have handed over to the other staff that Mr Bonaparte 'wasn't feeling too great'.
31. The officer told the investigator that he had interviewed Mr Bonaparte when he was on the induction wing and selected him as a suitable prisoner for East Tor. He did not know why Mr Bonaparte was under the care of the mental health team but said that the mental health support worker asked him into the meeting as Mr Bonaparte needed some reassurance that he could always talk to staff if he needed support and for staff to keep an eye on him. He did not know what the meeting had been about and did not think Mr Bonaparte was at risk of self-harm or suicide.
32. Mr Bonaparte saw a prison GP on 31 January. The GP wrote in Mr Bonaparte's clinical record that he looked low in mood, tired, drained, anxious and jittery. He prescribed an anti-depressant and arranged to see him again in three weeks time.
33. The mental health support worker saw Mr Bonaparte later that day and noted that he appeared less distressed than when she last saw him. He communicated well, and he talked about his girlfriend and about going to the gym. She encouraged him to approach staff if he had any concerns and he gave assurances that he would do so if he felt he needed support.
34. On 1 February, an assistant psychologist carried out a psychological assessment of Mr Bonaparte. He said he had split up with his girlfriend because of his needy behaviour. He felt trapped by his situation and difficulties

and could hit himself at those times to get rid of the frustration. She said that he asked himself what was the point of carrying on but did not have plans or the intent to harm himself and he felt '100% sure' he could keep himself safe. She wrote in his clinical record that their focus would be on psycho-education and anxiety management.

35. The assistant psychologist met with Mr Bonaparte again on 7 February. He said he had not felt any benefit from taking anti-depressants but he would continue until the GP review and would keep a diary of worries and thoughts that bothered him for discussion on 16 February. Mr Bonaparte kept his appointment with the assistant psychologist on 16 February.
36. On 21 February, a prison GP saw Mr Bonaparte for a medication review. He was still suffering from low mood and told the GP he did not have suicidal thoughts but was not feeling the benefit of seeing the assistant psychologist. The prison GP increased the anti-depressants dose and diagnosed mixed anxiety and depressive disorder.
37. Mr Bonaparte met the assistant psychologist on 23 February. He told her he had been struggling for the previous couple of days with managing his emotions around his relationship breakdown. He said he would try to limit the amount of contact he had with his ex-girlfriend.
38. Mr Bonaparte's telephone call records show that on 27 February he dialled his ex-girlfriend's telephone number 16 times between 1.00pm and 6.00pm, sometimes leaving voicemail messages or letting the phone ring.

## **28 February**

39. On 28 February, Mr Bonaparte dialled his ex-girlfriend's telephone number 14 times. They spoke at 4.27pm. She told him she did not wish to speak to him anymore.
40. An officer took over duty on East Tor at 4.15pm. It was not his usual place of work. He was on duty with another officer, who began supervising the evening meal at about 5.00pm. The servery workers, who checked off a list as each prisoner collected their meal, noted that Mr Bonaparte's meal remained uncollected and informed the officer. Mr Bonaparte was normally among the first prisoners to collect his meal and would often return for seconds. The officer telephoned the gym and library to see if he was there, while the other officer checked the corridors and healthcare centre.
41. When staff could not find Mr Bonaparte, a prisoner who worked with Mr Bonaparte in the gardens, glanced through Mr Bonaparte's door observation panel. He thought he saw him standing by his cupboard and he continued to walk to his own cell. Another prisoner walked towards Mr Bonaparte's cell and saw that the door observation panel was covered with a sheet of white paper, which seemed unusual. He opened the cell door and saw Mr Bonaparte hanging from a ligature, partially obscured by the wardrobe door which was open. He told the two officers who were in the staff office and they went into the cell.

42. One of the officers was shocked by the sight of Mr Bonaparte and froze. The other officer radioed an urgent message for staff assistance at 5.30pm. He did not use the emergency code, code blue (which indicates that a prisoner has breathing difficulties or is unconscious). He climbed onto Mr Bonaparte's bed and using a ligature-cutting tool, cut the ligature from Mr Bonaparte's neck. He told the investigator he did not think staff would respond if he radioed a code blue. He added that he was reluctant to say over the radio that he had found someone hanging as he did not want other prisoners overhearing what had happened.
43. An Operational Support Grade (OSG) who was on duty in the control room heard the officer's radioed message and transmitted a signal to all staff radios, which indicated there was a general alarm. South Western Ambulance Service records indicate that it received a 999 call from Dartmoor requesting an ambulance at 5.33pm. The OSG told the investigator he did not know what sort of incident had occurred and when he receives a radio message, he normally tries to gauge how serious it is before he calls an ambulance. He was initially unaware that Mr Bonaparte had been found hanging. He did not write down the actions he took in the communications log until the ambulance arrived.
44. Two officers arrived and began cardiopulmonary resuscitation. At 5.34pm, the custodial manager (the most senior officer on duty) arrived at East Tor and radioed an emergency code blue (indicating a prisoner with breathing problems) and requested a defibrillator, which was brought to Mr Bonaparte's cell at 5.36pm. The custodial manager told the investigator that he did not know before he arrived at Mr Bonaparte's cell that he had been found hanging. He said if he had known the nature of the emergency, he could have ensured that an ambulance had been called and that a defibrillator was taken to the cell while he was on his way to the incident.
45. After the code blue was called two nurses arrived at Mr Bonaparte's cell at 5.40pm with an emergency bag and oxygen. One of them told the investigator that she had heard the general alarm over the radio but had waited until the code blue was radioed before attending the scene. She examined Mr Bonaparte and did not see any signs of life. An officer attached the defibrillator to Mr Bonaparte and it advised that a shock should be administered. She inserted an airway into Mr Bonaparte's mouth to give breaths while an officer continued CPR, which continued until a first responder sent by the ambulance service arrived at 5.46pm. CPR continued until paramedics arrived at the cell at 5.55pm and Mr Bonaparte was placed in an automatic chest compressor.
46. An air ambulance arrived at the prison at 6.06pm. However, it was not used and Mr Bonaparte was taken to hospital by road ambulance at 6.45pm after being stabilised by paramedics. He was escorted by two officers but did not have mechanical restraints. At 8.22pm, doctors informed the officers that Mr Bonaparte had died.

### **Contact with Mr Bonaparte's family**

47. A senior prison manager telephoned Mr Bonaparte's parents to say that their son had been taken to hospital. They arrived at the hospital at 9.45pm and were told, inexplicably, that he had arrived by air ambulance. A nurse broke

the news of their son's death. A prison chaplain was appointed as Mr Bonaparte's parents' family liaison officer. The prison contributed to the cost of the funeral in line with national policy.

### **Support for prisoners and staff**

48. Managers debriefed the staff involved in the emergency response and offered support. Staff notified prisoners of Mr Bonaparte's death, and offered them support. Officers reviewed prisoners assessed as at risk of suicide and self-harm in case the news of Mr Bonaparte's death affected them.

### **Post-mortem report**

49. A post-mortem examination established the cause of death as compression of the neck. Toxicology tests showed that Mr Bonaparte was not under the influence of illegal drugs or alcohol at the time of his death. A low level of mirtazapine, an anti-depressant, consistent with his prescribed medication, was found in blood tests.

# Findings

## Mr Bonaparte's risk of suicide and self-harm

50. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff in contact with prisoners to be aware of the risk factors and triggers that might increase prisoners' risk of suicide and self-harm and take appropriate action. The PSI lists a number of risk factors and potential triggers for suicide and self-harm. These include young prisoners, early days in custody and following each transfer, a history of mental health problems, relationship instability, and impulsiveness. All staff should be alert to the increased risk of suicide or self-harm posed by prisoners with these risk factors. The PSI says that information received should be shared and acted on appropriately, including by opening an ACCT if necessary.
51. Mr Bonaparte arrived at Dartmoor with some known risk factors: it was his first time in custody, he was 23 years old and he had served only two months of his sentence. He told staff in reception and on the first night and induction wing that he had no thoughts of suicide or self-harm. However, he disclosed to the nurse that he had a history of depression and anxiety, and she referred him to the mental health team. In the absence of any other information that he was at risk, it was reasonable for them to conclude that Mr Bonaparte did not need to be monitored under ACCT procedures on arrival. As a new prisoner, he was closely monitored during the first few days of his induction period and staff did not have information which suggested he could be at risk.
52. However, ten days after his mental health assessment, Mr Bonaparte asked to see a mental health professional and appeared to be low in mood. An ACCT should have been opened by healthcare staff at that stage as there was sufficient information in his clinical record which indicated he was at risk. Mr Bonaparte had regular contact with a mental health support worker, an assistant psychologist and a GP. If they had opened an ACCT, the non-clinical staff would have been aware that he was vulnerable and could have monitored him. The continued failure to open an ACCT, particularly when he was clearly struggling with the breakdown of his relationship, which was so important to him, was a series of missed opportunities. Mr Bonaparte had disclosed some self-harming behaviours and that he was feeling depressed to healthcare staff but had not disclosed this to wing staff. They did not have access to his clinical notes and therefore were reliant on healthcare staff to share any information they had on risk.
53. It was unrealistic of a mental health support worker to expect an officer to handover to staff that Mr Bonaparte needed 'reassurance' without more information. The officer was unaware of the risk factors Mr Bonaparte was accumulating and the conversation Mr Bonaparte had had with the mental health support worker was not documented. If it had been, the triggers, which revolved around his relationship with his girlfriend, could have been noted and staff would have known that his break up meant he was entering a period of heightened vulnerability. Healthcare staff should have considered Mr Bonaparte's risk factors and set out why they decided not to open an ACCT. It is not possible to say whether opening an ACCT would have made a difference

to the eventual outcome but staff that had daily contact with Mr Bonaparte would have been aware of his state of mind and his potential risk.

54. A prison GP carried out a clinical review on behalf of the NHS. He concluded that Mr Bonaparte received the physical and mental health care that was equivalent to what he could have expected to receive in the community.
  55. He recommended that all clinical staff should have regular updates on identifying and managing prisoners with personality disorders, as he considered there was sufficient evidence in Mr Bonaparte's clinical notes to suggest this as a possible diagnosis of his feelings and behaviour, which could have influenced how clinical staff would have viewed his level of risk.
- **The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular they should ensure that:**
    - **staff understand the procedure for identifying, managing and supporting prisoners at risk of suicide and self-harm;**
    - **staff assess the risk of suicide and self-harm based on all available information and known risk factors and not on a prisoner's own presentation; and**
    - **staff understand the need to share all relevant information about risk.**

#### **Incident management and use of emergency codes**

51. PSI 03/2013 on medical emergency response codes requires staff to use a code blue or equivalent code in a medical emergency and for the control room to call an ambulance immediately an emergency code is used. The PSI is clear that prisons should not wait for healthcare staff or a duty manager to decide whether an ambulance is needed and that an ambulance can be cancelled later if not needed.
52. An officer failed to use the correct emergency code when he called for assistance at 5.30pm and the control room did not call an ambulance until 5.33pm. When a person is found hanging, any delay in calling an ambulance can be critical, literally a matter of life and death. Although Mr Bonaparte received prompt CPR from first aid trained staff, healthcare staff did not arrive until 10 minutes after the alarm was first raised as initially they were unaware that it was a medical emergency. It took staff 6 minutes to arrive from the healthcare centre with the appropriate equipment. The incident manager was unable to issue instructions while making his way to East Tor, as he did not know the nature of the incident until he arrived. Mr Bonaparte was unconscious but not dead when he was found. It is not possible to say whether the cumulative delay affected his chances of survival, but hypoxic brain injury occurs within five minutes of the brain being starved of oxygen. The importance of using the correct emergency code cannot be overstated.
53. Dartmoor's medical emergency response code local policy complies with PSI 03/2013 and is re-issued every 6 months. Yet staff are reluctant to follow it and create their own emergency codes in the belief that insufficient staff may attend

if they use the designated codes. The investigator was told by the Prison Officer's Association Branch Secretary that emergency codes were for healthcare staff only and officers were not obliged to attend. This local practice is at variance with national policy and is potentially dangerous.

**The Governor should ensure that all prison staff are aware of and understand PSI 03/2013 and their responsibilities during a medical emergency, including efficient communication of the nature of the emergency and ensuring there are no delays in calling an emergency ambulance.**

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