

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Edward Rudd, a prisoner at HMP Swaleside, on 15 July 2021**

**A report by the Prisons and Probation Ombudsman**



## Our vision

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



## Our values

We are:

**Impartial:** we do not take sides

**Respectful:** we are considerate and courteous

**Inclusive:** we value diversity

**Dedicated:** we are determined and focused

**Fair:** we are honest and act with integrity



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

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

Mr Edward Rudd died in hospital on 15 July 2021, after he was found hanging in his cell at HMP Swaleside on 9 July. He was 38 years old. I offer my condolences to Mr Rudd's family and friends.

Mr Rudd arrived at Swaleside on 24 November 2020. Throughout his time there, he gave no indication to staff that he was at risk of suicide or self-harm. I am satisfied that they could not have foreseen or prevented his actions.

During his seven months at Swaleside, Mr Rudd repeatedly asked for work because he was bored in his cell. While I accept that the COVID-19 pandemic meant that opportunities for work were more limited than usual, the prison could have been more helpful on some aspects, particularly in dealing with his complaint which was not handled correctly.

Mr Rudd relapsed into taking psychoactive substances (PS) shortly before he died. He also indicated to staff that he was holding PS for other prisoners in exchange for alcohol. On the day he was found hanging, he told staff that he had information about PS on the wing but was nervous about sharing it. I am satisfied that staff dealt with this appropriately.

I am concerned that there was a delay in calling a medical emergency code when Mr Rudd was found hanging and that the first nurse to arrive did not know how to use the defibrillator. I have previously made a recommendation to Swaleside about the use of medical emergency codes and am disappointed that I must do so again.

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 2022**

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# Summary

## Events

1. On 12 December 2019, Mr Edward Rudd was remanded in prison custody, charged with the attempted murder of his partner. He was released on bail on 21 August 2020. On 11 September, Mr Rudd was sentenced to 11 years and six months in prison. He was moved to HMP Swaleside on 24 November 2020.
2. During his time at Swaleside, Mr Rudd repeatedly asked for a job because he was bored in his cell. He was placed on waiting lists but was told that some jobs required course certificates. He said he had done the courses but had not received the certificates from a previous prison. When he put in a complaint, he was told to contact the previous prison.
3. Mr Rudd made frequent applications to his Prison Offender Manager about his sentence plan and numerous other issues. She responded to all his queries, but he subsequently put in a complaint. The response said that his Prison Offender Manager was aware of all his issues.
4. In June, Mr Rudd told substance misuse staff that he had been using psychoactive substances (PS). On 5 July, PS were found in Mr Rudd's cell. He told staff he was holding PS for other prisoners in exchange for alcohol.
5. On 9 July, substance misuse workers reported to staff that they thought three prisoners, including Mr Rudd, were under the influence of illicit substances. An officer and supervising officer (SO) went to see Mr Rudd. They said he did not appear to be under the influence. Mr Rudd told them he had information about PS on the wing but was nervous about sharing the information. The SO told him he could arrange a cell search so that he could be removed from his cell and then he would be able to talk to staff without being overheard. Mr Rudd also said that his ex-partner was trying to deny him access to his children, though he said he knew what to do and had it in hand.
6. At around 4.30pm, when an officer and SO were delivering meals to prisoners' cells, they found that Mr Rudd had barricaded his door. When they pushed their way in, they found Mr Rudd hanging from a light fitting. They cut him down and started cardiopulmonary resuscitation (CPR). The SO called a medical emergency code. Healthcare staff responded and an ambulance was called.
7. Mr Rudd was taken to hospital and placed in an induced coma. He died on 15 July after his life support was turned off. Toxicology results found that Mr Rudd's blood alcohol limit was over twice the legal driving limit. There was no trace of PS or drugs.
8. Mr Rudd left suicide notes saying he was no good to anyone and did not want to go on 'living this hell'.

## Findings

9. Mr Rudd gave no indication to staff that he was at risk of suicide or self-harm during his time at Swaleside.
10. It is difficult to say why Mr Rudd took the actions he did and whether it was linked with his involvement with PS. We consider that the SO dealt appropriately with Mr Rudd when he offered to share information about PS with staff.
11. We consider that Swaleside did not handle Mr Rudd's complaint about his course certificates correctly. Prison policy says that the current prison should deal with complaints about incidents at previous prisons.
12. We are satisfied that Mr Rudd's prison Offender Manager responded appropriately to all his queries.
13. There were delays with the emergency response. Staff did not call a medical emergency code straightaway when they found Mr Rudd hanging. The first nurse who arrived did not know how to use the defibrillator because she was not familiar with that model and asked for another to be brought.
14. The clinical reviewer found that the standard of care Mr Rudd received at HMP Swaleside was equivalent to that he could have expected to receive in the community. However, there was little evidence that substance misuse workers (Forward Trust) shared information about Mr Rudd's suspected substance misuse with healthcare staff, which was important because of Mr Rudd's medications.

## Recommendations

- The Governor should remind staff of their responsibilities during medical emergencies including that they should call the appropriate medical emergency code without delay.
- The Head of Healthcare should ensure that healthcare staff know how to use all the defibrillators in the prison.
- The Governor should ensure that prisoner complaints are handled in line with the Prisoner Complaints Policy Framework and that the prisoner is provided with a meaningful response.
- The Governor and Head of Healthcare should ensure that anyone working at the prison who becomes aware of prisoners using drugs or alcohol reports it to a member of staff and that healthcare staff are made aware.

## The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Swaleside informing them of the investigation and asking anyone with relevant information to contact her.
16. The investigator obtained copies of relevant extracts from Mr Rudd's prison and medical records.
17. The investigator interviewed seven members of staff during October and November 2021. NHS England commissioned a clinical reviewer to review Mr Rudd's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff and some custodial staff.
18. We informed HM Coroner for Kent and Medway of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
19. One of the Ombudsman's family liaison officers contacted Mr Rudd's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She raised a number of concerns and those that are in remit have been addressed either within this report or the clinical review. Other matters have been addressed in separate correspondence.
20. Mr Rudd's mother received a copy of the initial report. The solicitor representing her wrote to us pointing out an omission. The report has been amended accordingly. They also raised 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.
21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

## **Background Information**

### **HMP Swaleside**

22. HMP Swaleside, on the Isle of Sheppey, is part of the Long-Termleside and High Security estate. It houses up to 1,112 men serving sentences of four years or more. Integrated Care 24 Ltd provides primary healthcare. There is 24-hour nursing cover and a 17-bed inpatient unit. GPs work in the prison Monday to Friday, and Medway on Call Care provides an out of hours GP service. Oxleas NHS Foundation Trust provides mental health services. Forward Trust provides substance misuse treatment.

### **HM Inspectorate of Prisons**

23. The most recent published inspection of HMP Swaleside was in December 2018. Inspectors reported that many of those held at Swaleside were high risk and presented a high risk of harm to others and it was unquestionably a difficult place to run. They found that health services had improved since their last inspection and were reasonably good, but a few areas were still concerning. The pressures of chronic staffing shortages had started to reduce. Prisoners could access an appropriate range of primary care services and visiting specialists. Waiting times for primary care services were reasonable but too many prisoners did not attend their appointments.

### **Independent Monitoring Board**

24. 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 April 2021, the IMB found the prison had had a difficult year coping with the COVID-19 pandemic – at one point 150 staff were off work. Although they felt as a whole the prison had still managed to forge ahead and make some improvements regarding physical repairs and collaborative working, they remarked on the lack of meaningful activity/work available for prisoners which had been necessary to keep staff and prisoners safe.

### **Previous deaths at HMP Swaleside**

25. Mr Rudd was the 12th prisoner at Swaleside to die since July 2019. Eight of the previous deaths were from natural causes, two were drug-related and one was self-inflicted. We have previously made a recommendation about calling medical emergency codes promptly. A Notice to Staff was issued in January 2020 reminding them of the medical emergency procedures.

### **Assessment, Care in Custody and Teamwork**

26. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and

interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

27. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisons at risk of harm to self, to others and from others (Safer Custody)*.

### **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.

## Key Events

30. On 12 December 2019, Mr Edward Rudd was remanded in prison custody, charged with the attempted murder of his partner, and sent to HMP Bullingdon. He was released on bail on 21 August 2020. On 11 September, Mr Rudd was sentenced to 11 years and six months in prison and sent to HMP Bristol. He was moved to HMP Swaleside on 24 November 2020.
31. Mr Rudd had a history of depression and drug and alcohol abuse. When he arrived at Swaleside, he told staff he had attempted suicide three times in 2019 but had no current thoughts of suicide or self-harm. He said he did not need any support from the mental health team. A prison GP continued Mr Rudd's antidepressant medication.
32. On 23 December, an officer introduced himself to Mr Rudd as his key worker. Mr Rudd said he wanted a job as he was bored in his cell. Mr Rudd said he had put in an application for work and had been assessed as low risk. The officer told Mr Rudd about the types of jobs available and said that as Mr Rudd was an enhanced prisoner, there were more jobs available to him as long as his education was up to date. The office noted that Mr Rudd seemed happy with this.
33. In January 2021, Mr Rudd made two complaints. The first was that he had not received the activity packs he had ordered. (He was sent some the next day.) The second said he wanted access to a Purposeful Activities Pack giving details of opportunities available during a normal (non-COVID) regime. The response said there were folders on each wing with this information and gave a list of job and education opportunities.
34. On 5 February, Mr Rudd submitted a complaint because he wanted his food safety and mechanic certificates sent on from Bullingdon. The PPO was not provided with the prison's response, but Mr Rudd's appeal on 25 February suggests he was told his request should be sent to Bullingdon, which he was irritated about as he felt it was obvious the request was for Bullingdon. He received a response on 8 March saying that he needed to contact Bullingdon about the certificates.
35. On 15 February, Mr Rudd told his key worker that he had applied for a job in the kitchen but had been told that he needed to have completed a health and safety course. Mr Rudd said he had completed this but did not have the certificate. The officer told him that without a certificate he could not work in the kitchen so he would need to look at alternatives, such as 'the bins'. He subsequently made applications for a range of jobs and was placed on the waiting lists.
36. While he was at Swaleside, Mr Rudd made numerous applications to his prison Offender Manager. He was unhappy with his sentence plan and with his previous prison Offender Manager at Bristol and queried his release date. He also asked to be put on a specific course (and for a transfer out if it was not available at Swaleside), among many other things. His prison Offender Manager responded to all his queries. Mr Rudd submitted a complaint about the responses on 15 February. A prison manager responded and said that she had been made aware of his issues.

37. On 5 April, Mr Rudd submitted three further applications to his prison Offender Manager. He said he wanted it noted that a course he wanted to do was not available at Swaleside, that any work he did with Forward Trust (substance misuse service) would be a repeat of work he had already done at Bullingdon, and that nothing was ever explained to him such as why he had not been referred to the Psychologically Informed Planned Environment (PIPE) programme (specialised units that work with prisoners with complex needs – a PIPE referral was part of Mr Rudd’s sentence plan). His prison Offender Manager responded on 14 April. She said that the course he was interested in was offered at HMP Gartree and it was up to him to apply for a transfer there if he wished, that he could make his own PIPE referral, and she asked him to direct his other queries to Forward Trust.
38. On 9 April, Mr Rudd started sessions with Forward Trust (he had 15 sessions with them in total).
39. On 21 April, Mr Rudd was appointed as 'Children and Families Wing Representative', a voluntary role with Spurgeons (a charity that provides family support services for prisoners - they were helping Mr Rudd to maintain contact with his own children.) Mr Rudd was unlocked for two days outside of his normal association periods in order to do this work.
40. On 8 May, a member of staff submitted an intelligence report saying that they had seen Mr Rudd pass a vape to prisoners who seemed under the influence after using it.
41. On 12 May, an officer noted that Mr Rudd was starting work in the gardens the next day having been taken from the waiting list.
42. On 14 May, a worker from Forward Trust saw Mr Rudd because of reports he had been 'under the influence'. Mr Rudd was polite and talkative and said he had 'not used' in almost a year. She spoke with him about the implications of relapse and tolerance given he had not used for so long.
43. On 7 June, Mr Rudd submitted a complaint because he wanted to telephone his children but was unable to. On 18 June, he received a response saying that the prison had contacted his children’s mother about the matter. She had a No Contact order in place for Mr Rudd and did not want him to have her telephone number, but he was told he could still write to his children.
44. On 15 June, a forensic psychologist met with Mr Rudd to discuss a PIPE referral. She assessed that Mr Rudd met the initial criteria and added him to the waiting list for assessment. She told Mr Rudd that PIPE units prioritised referrals based on sentence length and warned Mr Rudd that, as he had 11 years left to serve, he may have to wait a while for an assessment which he understood.
45. On 18 June, an officer noted that Mr Rudd had asked when he could go to work. At the time COVID bubbles were being adhered to, and the officer noted that once restrictions were eased further and prisoners could mix, he would be out working.
46. On 22 June, Mr Rudd told Forward Trust staff that he had relapsed and was using psychoactive substances (PS). Mr Rudd said that things had escalated quickly, and he had gone 'from a place where he thought he was helping people to now being in

a place where he could exploit others for his own gain'. (Forward Trust staff thought he was holding and/or selling illicit drugs.) He started MET (Motivational Enhancement Therapy) meetings with them on 28 June.

47. On 5 July, an officer noted that a cell search had found Mr Rudd was in possession of six ID card size sheets of paper that had tested positive for PS. (Mr Rudd later told staff that he was holding the paper for others and was responsible for distributing PS on the wing in exchange for alcohol.)
48. Soon after, a Senior Family Practitioner with Spurgeons received an email from a Custodial Manager (CM) saying following the PS discovery, he would no longer support Mr Rudd's role with Spurgeons. She suggested a suspension as she considered he had impacted very positively on their service, but the CM did not think it was appropriate. She spoke to another CM, who agreed that Mr Rudd could remain in post, but that the prison would not allow him extra association time or to move freely to the west side. (She sent a letter to Mr Rudd on 7 July to tell him that he could continue in his role, but it is not clear if he received it.)
49. On 7 July, a drug and alcohol worker with Forward Trust told Mr Rudd he would not be able to attend the group meeting that day because of the recent adjudication. Mr Rudd asked when he would be able to attend again, and the worker said he did not know but that someone would speak to him about it soon.
50. The same day, the Senior Family Practitioner met with Mr Rudd. CAFCASS required a response to some questions for a report that would decide whether or not they would promote contact with his children. Mr Rudd was upbeat but when she asked him about his children, he became emotional. She offered to come back later on in the day, but Mr Rudd said it had just been a long day and he was fine to continue. Mr Rudd continued the question with no problems and was smiling and saying how he could not wait to see his children again. She considered Mr Rudd was his usual self by the end of the appointment. She asked him how he was feeling, and he said he was good and smiled.
51. That afternoon, the Senior Family Practitioner received an email from CAFCASS saying they were supporting that the children should make their own decision. she gave Mr Rudd the news and said he was overjoyed. She told him she would see him again in the week commencing 12 July.
52. On 8 July, the drug and alcohol worker told Mr Rudd that Forward Trust would continue to work with, but on more of a one-to-one basis, for two weeks rather than in a group. After two weeks they would consider whether he was suitable to re-join the group.

## **9 July 2021**

53. On 9 July, at approximately 2.30pm, two workers from the Forward Trust spoke to Mr Rudd through a crack in his cell door. One worker asked Mr Rudd if he was okay, and he said he was but that he was finding things difficult on the wing. He denied being under threat. He told Mr Rudd that he would have a one-to-one with him on Monday. He thought he could smell alcohol on Mr Rudd's breath.

54. Both workers from the Forward Trust told a SO in the wing office that they thought three prisoners may be under the influence, including Mr Rudd. The SO and an officer went to do a welfare check on the men, and Mr Rudd was the last to be checked.
55. The SO told the investigator that Mr Rudd did not appear to be under the influence of alcohol or drugs as he did not smell alcohol (though the SO said his smell had not recovered fully since being infected with COVID-19) and his speech was not slurred.
56. Mr Rudd said that he had information about PS on the wing but was nervous about who he could trust as he had shared information in the past, prisoners had found out and had then caused problems for him. The SO told the investigator that he tried to reassure Mr Rudd that it would be safe to share the information, but he did not want to pressure him. Mr Rudd asked if his cell could be searched so that he would have an opportunity to speak to staff while he was out of his cell. The SO said he could arrange this.
57. Mr Rudd also said he was under pressure to hold PS and did not want to be part of it. He said he could look after himself if needed but would rather avoid any difficult situations. The SO said he would look into a possible wing move.
58. The SO asked Mr Rudd if he had any other issues and he said he had issues with his prison Offender Manager. He said he had put in numerous applications for her to see him but had not heard back. The SO said he would ask the prison Offender Manager to see him. Mr Rudd also said he had lost his job with Spurgeons but intended to get it back. He mentioned that his ex-partner was trying to deny him access to his children, but he knew what to do in this situation through his work with Spurgeons and had it in hand.
59. At approximately 4.30pm, the SO and an officer started giving prisoners their meals in their cells. The SO was unable to open Mr Rudd's cell, as he had barricaded it with a cabinet. He pushed his way in and shouted for the officer to help him.
60. Mr Rudd was suspended from the light fitting. The SO cut him down with his fish knife (a tool for cutting ligatures) and the officer entered the room. The SO asked him to start CPR. The officer noticed another ligature around Mr Rudd's neck, cut it off and started CPR.
61. The SO called a code blue over his radio, but the line was busy, and he thought no one had heard him call the code. He pressed the personal alarm button on his radio which instructs staff in the control room to set off a general alarm. Another SO, and two more officers responded.
62. The control room log shows a general alarm was called at 4.32pm and a code blue at 4.37pm. The ambulance records say they received a call at 4.37pm.
63. The SO went to the treatment room to tell a nurse that he needed her assistance, but she had heard the code blue and was already on her way as she was on the wing giving out medication.
64. The other SO returned to the scene and took over CPR from an officer. Another SO assisted by holding the ambu-bag. The nurse could not get the defibrillator to

work, and someone brought a replacement from the wing office straightaway. The healthcare first responder (Hotel 1) and a prison GP also attended.

65. The nurse had applied the replacement defibrillator which advised 'no shock'. Officers continued with CPR and paramedics arrived at 5.07pm.
66. Mr Rudd left suicide notes saying that he was no good to anyone and did not want to go on 'living this hell'. He maintained his innocence.

## **9 – 15 July**

67. Mr Rudd was taken to hospital at 5.53pm and admitted to the Intensive Care Unit. He was accompanied by two officers who stayed in the hospital's family area. Restraints were not applied at any point and family visits were allowed.
68. On 15 July, at approximately 7.00pm, hospital staff turned off Mr Rudd's life support machine. The escorting officers waited outside the room while this was done. Mr Rudd died that evening.

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

69. On 9 July, the prison appointed an officer as the family liaison officer. She telephoned Mr Rudd's family as soon as Mr Rudd had been taken to hospital. She maintained contact with the family during Mr Rudd's time in hospital offering support and answering questions.
70. The prison contributed to the costs of Mr Rudd's funeral in line with national policy.

## **Support for prisoners and staff**

71. After Mr Rudd was taken to hospital, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
72. The prison posted notices informing other prisoners of Mr Rudd'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 Rudd's death.

## **Post-mortem report**

73. The post-mortem report concluded that the cause of Mr Rudd's death was hanging. The toxicology report noted that Mr Rudd's blood alcohol level was over twice the legal driving limit.

# Findings

## Management of Mr Rudd's 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)*, sets out the procedures (known as ACCT) that should be followed when a prisoner is identified as being at risk of suicide and self-harm.
75. Mr Rudd was managed under ACCT for a short period when he was first remanded in prison custody in December 2019. Mr Rudd was not managed under ACCT after he returned to prison following sentencing in September 2020. We consider that was reasonable. Mr Rudd showed no indication that he was at risk of suicide or self-harm while he was at Swaleside.

## Substance misuse

76. It is difficult to say why Mr Rudd took the actions he did, but we know that he had relapsed into taking psychoactive substances (PS) shortly before he died, which can have a detrimental impact on mental health. Also, Mr Rudd told staff that he had become involved in holding PS for other prisoners in exchange for alcohol. Alcohol was found in Mr Rudd's system when he died, though there was no trace of PS.
77. On the day he was found hanging, Mr Rudd told staff that he had information about PS on the wing, but he was nervous about sharing it with staff. Based on what he told us at interview, we consider that the SO handled this appropriately. He said he did not pressure Mr Rudd and told him that he could arrange a cell search so that Mr Rudd could be removed from his cell and could share information with staff without being overheard.
78. In terms of a strategy to tackle drug and alcohol use, Swaleside has a detailed Drug, Alcohol and Substance Misuse Strategy, which was updated in April 2021. The last HMIP inspection in December 2018 noted considerable problems, but a follow-up review in October 2019 found that new strategic measures had successfully reduced drug use and supply. We make no recommendation.

## Emergency response

79. PSI 03/2013, *Medical Emergency Response Codes*, requires all prisons to have a medical emergency response code protocol in place, the purpose of which is to ensure a timely, appropriate and effective response to medical emergencies. When a medical emergency is discovered, staff should call the appropriate medical emergency code straightaway so that relevant staff, including healthcare staff, are alerted, the correct equipment is brought, and an ambulance is called immediately.
80. There was a delay in calling the medical emergency code when staff discovered Mr Rudd hanging. The SO called a code blue but only after he had cut Mr Rudd down. Staff should have called a code blue as soon as they saw Mr Rudd hanging rather than cutting him down first. We recognise the dilemma staff in this situation face but it is important that the code is called immediately so that healthcare staff are alerted, and an ambulance is called. We recommend:

**The Governor should remind staff of their responsibilities during medical emergencies including that they should call the appropriate medical emergency code without delay.**

81. We are concerned that the nurse did not know how to work the first defibrillator and asked for another to be brought to her. When interviewed, she said that she did not realise that there was a tape in the battery compartment that had to be pulled out. The second defibrillator was brought quickly, but we consider that healthcare staff should know how to use any defibrillator. We recommend:

**The Head of Healthcare should ensure that healthcare staff know how to use all the defibrillators in the prison.**

### Mr Rudd's interactions with his Prison Offender Manager

82. Mr Rudd made numerous applications to his prison Offender Manager. He appeared frustrated with aspects of his sentence plan and availability of courses, among other things. We consider that the prison Offender Manager responded appropriately to his concerns. We note that a PIPE referral, which was part of his sentence plan, was made, but as Mr Rudd was only a few months into a long sentence, he was not a priority referral.

### Mr Rudd's frustrations with lack of work

83. Mr Rudd told staff that he was bored in his cell and that he wanted a job, so he was kept busy and had more time out of his cell. We recognise that it was a difficult time for the prison because the COVID-19 pandemic meant that the prison was unable to run a normal regime, which meant that work opportunities were more limited than usual. However, we consider that the prison could have done more to assist him, particularly around helping him to obtain his course certificates from Bullingdon.
84. In response to Mr Rudd's complaint about this, the prison said he should contact Bullingdon. This is not in line with prison policy. The Prisoner Complaints Policy Framework says that where a complaint relates to an incident at a previous prison, the current prison is responsible for dealing with it (and for getting a response from the previous prison if necessary). We recommend:
85. **The Governor should ensure that prisoner complaints are handled in line with the Prisoner Complaints Policy Framework and that the prisoner is provided with a meaningful response.**

### Clinical care

86. The clinical reviewer was satisfied that the care Mr Rudd received at Swaleside was equivalent to that he could have expected to receive in the community. However, he had some concerns about information sharing.
87. The clinical reviewer noted that there was evidence of information sharing about Mr Rudd's use of illicit substances between Forward Trust, Spurgeons and prison staff. However, the clinical reviewer could find no evidence that information about Mr Rudd's drug and alcohol use was shared with healthcare staff, who should have been made aware given that Mr Rudd was on high dose antidepressants. The

clinical reviewer considered it even more important in Mr Rudd's case as it was documented that his suicidality increased with alcohol use. We recommend:

**The Governor and Head of Healthcare should ensure that anyone working at the prison who becomes aware of prisoners using drugs or alcohol reports it to a member of staff and that healthcare staff are made aware.**

**Prisons &  
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