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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the circumstances surrounding the  
death of a man at HMP Spring Hill  
in December 2013**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man who was found hanging in the chapel at HMP Spring Hill on 28 December 2013. He was 42 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the man's clinical care at Spring Hill. The prison cooperated fully with the investigation.

The man was sentenced to life imprisonment in December 2001. He had spent previous periods in Spring Hill and returned there in August 2013. He was highly regarded by staff and his death came as a surprise to those who knew him. We do not know the reasons for the man's actions. However, on the afternoon of his death, he had spent some time in the chapel with two other prisoners and was said to be emotional and upset about the recent refusal of an application for temporary release and the anniversary of his mother's death.

The man gave little sign to staff, or those around him, that he was in such distress and I am satisfied that prison staff could not have been expected to predict or prevent his actions on 28 December. The investigation found that the emergency response when the man was found hanging, did not follow local or national procedures and an ambulance was not called immediately as it should have been. I am also concerned that a decision not to attempt resuscitation was taken on the basis of a belief that the man had died, rather than because there were clear physical signs that attempts at resuscitation would be futile. I acknowledge that Spring Hill rarely experiences such incidents, but staff need to be better prepared and confident about handling medical emergencies.

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**September 2014**

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## SUMMARY

1. The man was convicted in December 2001 and sentenced to life imprisonment for robbery, burglary and possession of an imitation firearm, with a minimum period to serve of three and a half years. At the time of his arrest, he was addicted to heroin and crack cocaine. He had no history of self-harm, but a few years earlier had been diagnosed with depression. The man served time in a number of prisons, including Spring Hill in 2009 and 2011. Each time, he went back to closed conditions after failing drug tests.
2. The man returned to Spring Hill on 20 August 2013. He worked as a painter and decorator at both Spring Hill and Grendon and received many positive reports.
3. On 15 December, the man applied to have a town visit on 22 December, to spend the day with a friend. The application was refused on 20 December and, in telephone calls that day, he expressed anger at the decision. Two days later, the manager of Spring Hill explained to him that they considered he had not yet been fully tested in open conditions and there was insufficient information about the friend he was intending to meet. They were also concerned that he might have a chance meeting with his victim, who they thought lived locally.
4. At lunchtime on 28 December, the man asked two other prisoners to go to the chapel with him. (Prisoners who knew him said that they had never known him to go to the chapel.) He spoke to them about things that were worrying him, including the anniversary of his mother's death and he repeatedly mentioned the refusal of his application for day release. The prisoners described him as emotional and upset and said that he had cried several times during their conversation. After they had finished, the man asked the other prisoners to return to the chapel in half an hour. They agreed to do so, but both became distracted with other tasks and did not go back at the agreed time. CCTV shows that the man later returned to the chapel with something under his jacket and went back a third time at 2.50pm.
5. At around 3.10pm, a prisoner went to the chapel, where he found the man hanging from a beam by a ligature made from a bed sheet. He alerted officers, who went back to the chapel with him, calling for assistance on the way. Healthcare staff from Grendon responded and a manager called an ambulance. The staff who attended the incident decided not to attempt resuscitation as they believed he was dead. An air ambulance arrived at 3.29pm and the doctor from the crew pronounced him dead at 3.36pm.
6. The investigation found that when the man was discovered hanging, national instructions for emergency incidents and the use of emergency codes were not followed, therefore healthcare staff were initially unaware of the nature of the emergency and an ambulance was not called promptly. Although it appears unlikely that resuscitation would have been successful, we consider that cardiopulmonary resuscitation should have been attempted as soon as the man was found.

## THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Spring Hill, informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.
8. The investigator went to Spring Hill on 8 January 2014 and obtained copies of the man's prison and medical records. She interviewed seven members of staff and five prisoners at Spring Hill on 4 and 5 February 2014 and wrote to the Governor on 7 February 2014, to give feedback on the initial findings of the investigation.
9. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison. The clinical reviewer joined the investigator for some of the interviews.
10. We informed HM Coroner for Buckinghamshire of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.
11. One of the Ombudsman's family liaison officers contacted the man's sister and his cousin, his nominated next of kin, to explain the investigation and invite them to identify any relevant issues they wanted the investigation to consider. His cousin said she spoke to him each week and he had given no indication of his intentions. She therefore wanted to know whether anything had happened to trigger the man's actions. The man's family received a copy of the draft report. The solicitor representing them wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.
12. It was appropriate for two issues the solicitor raised to be included in the final report so that the prison is aware. The first is that the man's family were unhappy and distressed that a representative from the prison had given them incorrect information about where the man had died. Also, the clothes he died in were included among his personal effects which were forwarded to his family. This was particularly distressing as they had not been forewarned.

## **HMP SPRING HILL**

13. HMP Spring Hill is an open prison near Aylesbury in Buckinghamshire. It holds up to 334 prisoners, most of whom are longer sentenced prisoners within the last few years of their sentence. Spring Hill is jointly managed with the neighbouring HMP Grendon. The two prisons share a number of common services, but operate as separate units. Spring Hill's purpose is to prepare prisoners for release by addressing offending behaviour needs, as well as to help prisoners find accommodation and employment on release. A key part of this process is a scheme that allows prisoners to work in the local community.
14. Healthcare at Spring Hill consists of an outpatient facility, staffed by healthcare staff from Grendon. Prison doctors hold surgeries three days a week. In addition, prisoners have full access to clinic facilities at Grendon.

## **HM Inspectorate of Prisons**

15. HM Inspectorate of Prisons carried out an unannounced short follow-up inspection of Spring Hill in March 2012. (The previous full inspection had been in August 2008.) The Inspectorate found that Spring Hill was safe and generally well run. There had been very few incidents of self-harm as high priority had been given to suicide and self-harm prevention and the use of Listeners to support other prisoners in distress had improved. Although there were very good relationships between staff and prisoners, there was no effective personal officer scheme to provide one to one engagement or identification of vulnerable prisoners who needed support. Entries in prisoners' records were usually facts about them, rather than an understanding of their personal circumstances or concerns.

## **Independent Monitoring Board**

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the community who help ensure that prisoners are treated fairly and decently. In its most recent report, the Board said that managers and staff were very committed to safer custody but safer custody meetings had not been well attended.

## **Previous deaths at Spring Hill**

17. This is the second death of a prisoner at Spring Hill since 2004, when the Ombudsman began investigating deaths in prisons in England and Wales. The previous death, in December 2009, was due to natural causes and there were no similarities in the circumstances.

## KEY EVENTS

18. The man was arrested for aggravated burglary, robbery and possession of an imitation firearm in December 2000. He was convicted in December 2001 and sentenced to life imprisonment, with a minimum period to serve of three and a half years. His offences were linked to his addiction to heroin and crack cocaine. A few years before his imprisonment, the man had been diagnosed with depression, triggered by unemployment, for which he had been prescribed antidepressants. He had no history of self-harm.
19. The man spent time in several prisons, including HMP Wormwood Scrubs, HMP Swaleside and HMP Grendon. He transferred to Spring Hill in 2009 and 2011, but on both occasions, returned to a closed prison, HMP Bullingdon, after testing positive for opiates. Staff considered the positive drug tests had raised his risk of absconding and made him unsuitable for open conditions. At Bullingdon, the man received many positive reports and was described as hardworking and proactive, often offering to assist with additional tasks.
20. The man's prison records show that on 29 January 2012, his aunt had told him that his mother had died two days earlier. Prison chaplaincy staff offered him support.
21. Many prisons operate a personal officer scheme to allow an appointed officer to develop more effective relationships with individual prisoners to help address their needs and act as a point of contact for advice and assistance. The man's personal officer at Bullingdon, held meetings with him at least once a month and made frequent entries in his personal record. In June 2012, he told her that a Parole Board hearing was due in March 2013 and that the administrative process would begin soon. At a meeting with his personal officer at the end of August, they discussed the impending hearing. The man told her he hoped to be released as he had completed eight years more than his tariff. Several subsequent entries by his personal officer noted that he was focussed on the parole hearing. He received the outcome on 8 April and was told that he could move back to open conditions. Despite the positive outcome, the man's personal officer noted he appeared disheartened as he thought he might have to stay at Spring Hill for a long time before he would be released.
22. On 20 August 2013, the man returned to Spring Hill. He had health screens with a nurse and a doctor, who found no evidence of emotional or mental health problems. He reported no problems with alcohol misuse and said he had been drug-free since 2011. He was prescribed medication for diabetes, high cholesterol and pain relief for back pain.
23. The man was employed as a painter and decorator. His personal record contains numerous entries about his positive behaviour, including occasions where he volunteered for additional work, often in his own time and without additional pay. An entry on 8 November 2013, noted that he had volunteered to assist with the renovation of the prison gates. This was considered a

responsible position as he would work unsupervised beside a public road.

24. On 15 December, the man applied for day release to spend the day with a friend in Oxford on 22 December. (Prisoners in open prisons can apply for day release for visits near the prison with friends and family, as part of their preparation for release back into the community.) A board at the prison, considered his request on 20 December. It was chaired by the head of the Spring Hill site, and comprised an offender supervisor (an officer responsible for helping a prisoner to meet the objectives of their sentence plan) and a prison officer. They turned down his application as they considered his reliability in open conditions had not yet been sufficiently tested.
25. The investigator listened to a recording of a telephone call on 20 December, between the man and the friend he wanted to visit. He said he was, upset that his visit had been refused and would talk to his offender supervisor. He commented that he had been better off in Bullingdon and said he was very angry about the decision.
26. The head of the Spring Hill told the investigator that the man had been considered to be medium risk to the public and low risk on all other factors, such as risk of escape. However, three main concerns had led to the refusal of his application. They did not know very much about the friend he was proposing to visit and thought there was a possibility of a chance meeting with his victim. The third concern was that after transferring to Spring Hill, he had spent a lot of time working as a painter at Grendon, in closed rather than open conditions so he had yet to be fully tested.
27. The head of the Spring Hill site said he had discussed the reasons with the man two days after the decision had first been communicated. The man had said that he was disappointed, but understood the reasons. He told the head of the Spring Hill site that he was not in a relationship with the woman he had intended to visit, she was a friend who visited him in prison and was therefore aware of his background. He also said that his victim had moved from Oxford to Manchester. He was confident that the questions raised could be easily resolved.
28. The man spent Christmas day with his room mate. The man's room mate told the investigator that they had began sharing a room in November and had got on well. He had last seen the man at lunchtime on 28 December, when the man had asked him to tell a particular prisoner (he could not remember who) that he was in the chapel. The man had told him that he had been refused day release and, a few days before Christmas, he had mentioned that the first anniversary of his mother's death was approaching. The man's room mate had not noticed anything unusual or of concern about the man in the period leading up to his death and said he had not said or done anything to suggest that he would harm himself.
29. A close friend of the man who worked with him as a painter, told the investigator that during a conversation five weeks before his death he had said, "I can't go on like this ... I can't do no more of this prison life". The

man's friend said that at the time, he seemed quite distant and talked about concerns about being released and the possibility of being recalled in the event he was released. The man's friend tried to help him by suggesting work plans for the future. He said that the man thanked him the next day for being supportive. The man's friend added that in the weeks leading to his death, their manager at work had also noticed the man's demeanour and asked if he was all right. While they were painting at Grendon, The man's friend had asked him what had triggered his thoughts and concerns and the man had said that going back into the room where he used to have therapy had brought back memories.

### **Events on 28 December**

30. In a statement to the police an operational support grade at Spring Hill, said that, at around 1.15pm on Saturday 28 December, a colleague asked her to unlock the chapel. On her way there, she met the man and another prisoner who wanted to use the chapel. While she was unlocking the back door, she had a conversation with the man, who she had known for many years. She told the investigator that he had seemed normal and happy to her and not down or upset.
31. A prisoner who had known the man for several years, said that, after lunch that day, the man appeared to be down and had asked him and another prisoner to go with him to the chapel. He seemed eager to go there. They walked over and a member of staff opened the door for them. The other prisoner arrived shortly afterwards.
32. The prisoner said that the man spoke about several things that were bothering him. He told them that he was upset as it was the anniversary of his mother's death and he had not been able to attend her funeral. He also said he had been refused day release over Christmas although he felt he had gone above and beyond to earn it. He mentioned that he was in debt, but did not say what had led to this. The prisoner said that, throughout the hour or so that they had spoken, the man had been deeply upset and emotional and had cried four times. He repeatedly said that he thought that he was always being punished by God. When the prisoner asked him if he felt depressed, he had said no. The other prisoner read passages from the bible to try and help the man and the three of them held hands and prayed. The prisoner and the man then returned to the prisoner's unit, where they had coffee and a cigarette. The man said he intended to go back to the chapel and asked him to meet him there in half an hour. He replied that he would try to do so, but was then busy with other things and did not return.
33. The other prisoner said he had first met the man in the induction unit in August. They did not socialise but on a few previous occasions, the other prisoner had asked the man to join him to pray and he had always refused. At around 1.15pm, just after the prisoner had returned from a town visit, the man asked him to go to the chapel. He noticed that his face was red, as if he had been crying. He joined him and the prisoner at the chapel and the man began to cry. He told them that people hated him and his family thought he was evil.

He also mentioned the anniversary of his mother's death. The prisoner said that he repeatedly spoke about the refusal of his day release but, after praying, he thought he seemed happier. The prisoner decided to get some coffee and the man asked him to come back in half an hour. He told the man he could wait for him in the chapel, but the man decided to get some coffee too. He asked the prisoner again if he was sure he would return in half an hour. However, the prisoner did not go back as he had spent an hour talking to another prisoner. At about 4.00pm, another prisoner reminded him that he had said he would go back to the chapel to see the man. When he asked to do so, staff told him it was out of bounds.

34. The investigator reviewed CCTV footage of the man's visits to the chapel. It showed that he was in the chapel at 12.30pm and left at 1.15pm. At 2.28pm, he went back into the chapel, with something under his jacket. The CCTV shows the man leaving the chapel at 2.45pm and returning a final time at 2.51pm.
35. Another prisoner, said that he had returned from five days home leave at about 3.00pm. After going through reception, he went straight to the chapel, where he usually spent a lot of time, often on his own and also in workshops as a peer supporter. CCTV footage shows this prisoner going into the chapel at 3.10pm. As he went up the stairs, he saw the man hanging from what appeared to be part of a green bed sheet attached to a beam. At first, he thought it was a prank. He went up to him to get him down, but realised he could not do it on his own so he ran to the prison reception to get help. He told two officers what had happened and the three of them ran back to the chapel. The prisoner said he had never seen the man in the chapel before.
36. At interview, one officer said that he had radioed an emergency code blue at around 3.08pm and as he received no reply to his first call, he repeated his message. (A code blue indicates symptoms such as a prisoner who is not breathing or is unconscious.) He explained that the radio was not on 'talk through' so the message went directly to control room staff, who then relay the emergency call to healthcare and other staff.
37. Two support officers on duty in the communications room, said that at approximately 3.11pm they received a call from one of the officers asking for healthcare staff to attend the chapel immediately, but were given no other information. A support officer sounded the emergency siren and asked the duty governor and the duty general managers at both Spring Hill and Grendon to acknowledge the call.
38. When the two officers arrived at the chapel with the prisoner, another officer held the man's legs and eased the tension of the ligature, while the prisoner climbed on a chair and used the officer's anti-ligature knife to cut the sheet. The officers noticed that the man's pupils were dilated and neither of them could find a pulse or other signs of life. Another officer then cut the ligature from around his neck. The officer advised him not to attempt resuscitation.

39. Spring Hill's custodial manager and the duty governor said that, at around 3.10pm, they heard a call for urgent medical assistance and went to the chapel. The custodial manager saw the officer checking for a pulse, but he said he could tell from the pallor of the man's skin that he was dead. He then radioed to request an ambulance, which the control room staff timed as 3.14pm. Two nurses arrived a few minutes later.
40. A nurse said that at 3.10pm, while on duty at Grendon, she had received a radio call asking her to attend Spring Hill. No code was used and she was given no information about the incident or whether it was urgent. At interview, she said this had not caused a delay as she and her colleague, another nurse had responded quickly, but she felt that they would have been better prepared mentally had they known the nature of the incident. The two nurses immediately left Grendon and when they arrived at Spring Hill collected keys and the emergency bag from the healthcare centre. A support officer helped them to carry the bag to the chapel and, on the way, they were told the man had been found hanging. The nurse said she then contacted the control room to ensure that an emergency ambulance had been called. (The control room log noted a call from the nurse at 3.24pm.)
41. When the nurses arrived at the chapel, the staff present had not attempted resuscitation. The nurse examined the man and found no pulse, heartbeat or chest sounds. He was lukewarm, his pupils were fixed and dilated and his tongue and face were swollen. Both nurses concluded that resuscitation would be inappropriate. An air ambulance arrived at 3.29pm with a doctor and paramedics. They confirmed that there were no signs of life and the doctor certified the man's death at 3.36pm.

#### **Events after the man's death**

42. At 8.20pm, the duty governor and the prison's family liaison officer, went to the home of the man's ex-wife, who had been listed as his next of kin, to break the news of his death. She was not at home, but her lodger telephoned her and, as she was unable to return, the duty governor told her of the man's death over the telephone. His ex-wife said that they had been divorced for a number of years and she did not wish to act as next of kin, but she would try to find the contact details of the man's sister.
43. At 12.30pm on 29 December, the duty governor telephoned Thames Valley Police. She asked them to liaise with the Scottish Police to inform the man's cousin, who had been listed as an emergency contact. At 4.00pm, the police confirmed that the message had been delivered to the man's cousin. The duty governor spoke to the man's cousin and sister frequently and the prison offered to pay the funeral costs.
44. The day after the man's death, the Governor held a debrief meeting for the staff involved in the emergency and reminded them of the support services available. At the meeting, there was concern that a number of staff did not carry anti-ligature cut-down tools and that the emergency bag was very heavy. The nurse told the investigator that, since the man's death, lighter

emergency bags had been introduced.

45. The prisoners who were with the man before his death said they had been well supported by prison managers and staff over an extended period.
46. The post-mortem report concluded that the man had died from hanging. No illicit substances were found in his system.

## ISSUES

### Clinical care and risk of suicide and self-harm

47. The man had suffered reactive depression several years before his imprisonment, but had no history of self-harm. He had been addicted to heroin and crack cocaine and continued to take illicit drugs in prison until 2011. When he arrived at Spring Hill in August 2013, he had a full health assessment. This included questions about his behaviour, emotional and mental state and substance use. Healthcare staff had no concerns about him and prescribed medication for existing physical health conditions, diabetes, high cholesterol and back pain. The clinical reviewer concluded that the man had received excellent care at Spring Hill, exceeding that in many GP practices. He noted that the man's actions had come as a surprise to all who knew him. We are satisfied that there was nothing to indicate to staff that the man was at risk of suicide and self-harm and they could not have been expected to predict the man's actions.

### Emergency response

#### *Emergency response code*

48. Prison Service Instruction (PSI)03/2013 *Medical Emergency Response Codes*, issued in February 2013, contains mandatory instructions for governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies. As required by the PSI, Spring Hill issued a local emergency protocol on 15 February 2013.
49. There are conflicting accounts as to whether a code was used when the emergency was reported. The officer said that he radioed a code blue to the control room for them to relay the message for assistance to healthcare and other staff. As the first message had not been received, he repeated it. The nurses who attended said that no code had been called so they were initially unaware of the nature of the emergency and an officer had told them as they approached the chapel. The support staff who had received the call in the control room, said they had been asked to request immediate assistance from healthcare staff, but had been given no other information. The investigation has been unable to resolve the varying versions of events as the emergency call was not recorded. It is therefore not clear whether the confusion about the code was due to staff error, mishearing of the message or a misunderstanding of responsibilities.

#### *The time taken for nurses to arrive at the chapel*

50. Spring Hill shares medical facilities with HMP Grendon and the nurses who attended were stationed there. It took around ten minutes for them to arrive at

the chapel from Grendon as they had to go through several gates, return their keys and pick up a fresh set at Spring Hill in order to collect the emergency bag from the Spring Hill healthcare centre. The nurse did not consider that the absence of an emergency code had impacted on the speed of their arrival. We are satisfied that, taking into account the distance between the two sites, there was no undue delay in the nurses reaching the chapel, but there may be scope for examining ways of ensuring emergency equipment is taken to incidents at Spring Hill to be ready for healthcare staff when they arrive so that they can go straight to the scene of the emergency.

### *Calling an ambulance*

51. Neither the first two staff at the incident, were aware of the national instructions or Spring Hill's local emergency protocol and were unclear as to who was responsible for calling an ambulance in serious emergencies. The custodial manager requested an ambulance after he arrived at the chapel and the nurses checked that this had been done. The nurses believed the first person at the scene should call an ambulance. The head of the Spring Hill site, the head of site, explained his understanding that it was the responsibility of staff at the scene with the most up to date information to call or request an ambulance.
52. Both the national PSI and Spring Hill's local protocol stipulate that if an emergency code is called, an ambulance must be called automatically. However, Spring Hill's instruction goes on to say, "the process for reporting an incident remains as before ..." in the event of a code blue or red, staff should state if an ambulance is required. Although in this incident, the ambulance was called as a result of a specific request and not a code, this advice to staff is contradictory and conflicts with the principle that an ambulance should be called automatically and then cancelled if it is subsequently decided that it is not required.
53. The advice in Spring Hill's protocol for medical emergencies is not fully compliant with Prison Service guidelines, staff are unfamiliar with it and it seems that during this incident, there was a lack of clarity about respective roles. We therefore make the following recommendation:

**The Governor should ensure that all prison staff are made aware of PSI 03/2013 and understand their responsibilities during medical emergencies and that Spring Hill has a medical emergency response code protocol which:**

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency;**
- **Ensures staff called to the scene bring the relevant equipment; and**
- **Ensures there are no delays in calling, directing or discharging ambulances.**

## *Resuscitation*

54. After the officers cut down the man, they found no pulse. They said his physical appearance suggested he was dead so they decided not to attempt resuscitation. However, the officer said that the man's body did not feel stiff. Neither of the officers had up to date first aid training. When the two nurses arrived, they too decided not to start resuscitation. The nurse described the man as, "lukewarm" and the nurse said there was no sign of rigor mortis and he was, "still warm to touch".
55. The clinical reviewer notes, "The Resuscitation Council (UK) says that resuscitation should be carried out until qualified help arrives, either a doctor or a paramedic, unless resuscitation is impossible because there are clear signs of rigor mortis". He adds that it is questionable as to whether the guidelines were followed as there was no evidence of rigor mortis, but he acknowledges it is a very difficult clinical decision and that resuscitation when the man was first found would not necessarily have changed the outcome. Death by hanging can occur very quickly.
56. The man was seen to enter the chapel around ten to 20 minutes before he was found. It is vital that if a person is unconscious cardiopulmonary resuscitation is started as soon as possible to improve the chances of survival unless there are clear signs of death such as the onset of rigor mortis which would indicate that resuscitation would be futile. None of the staff who saw the man indicated that rigor mortis was evident. We acknowledge that at a prison such as Spring Hill staff do not often need to use resuscitation skills, but for that reason it is important that they understand what is required in such an emergency. We therefore make the following recommendation:

**The Governor and Head of Healthcare should ensure that staff receive sufficient guidance and training to understand the benefits of immediate cardiopulmonary resuscitation for a prisoner who is not breathing and that resuscitation should be attempted, unless there is clear evidence that it would be futile in the circumstances.**

## RECOMMENDATIONS

1. The Governor should ensure that all prison staff are made aware of PSI 03/2013 and understand their responsibilities during medical emergencies and that Spring Hill has a medical emergency response code protocol which:
  - Provides guidance to staff on efficiently communicating the nature of a medical emergency;
  - Ensures staff called to the scene bring the relevant equipment; and
  - Ensures there are no delays in calling, directing or discharging ambulances.
  
2. The Governor and Head of Healthcare should ensure that staff receive sufficient guidance and training to understand the benefits of immediate cardiopulmonary resuscitation for a prisoner who is not breathing and that resuscitation should be attempted, unless there is clear evidence that it would be futile in the circumstances.