



National Offender
Management Service

[REDACTED]
**Equality, Rights and Decency
Group**

National Offender Management Service
4th Floor, Clive House,
70 Petty France,
London, SW1H 9HD
[REDACTED]

Kate Thomas
HM Assistant Coroner
HM Coroner's Court
Archbishops Palace
Mill Street
Maidstone
ME15 6YE

August 2016

Dear Ms Thomas

Regulation 28 report concerning the inquest into the death of Ronnie Olliffe on 1 October 2014 at HMP&YOI Rochester.

Thank you for your report addressed to the Governor of HMP&YOI Rochester concerning the inquest into the death of Mr Olliffe. Your report has been passed to Equality, Rights and Decency Group in NOMS, as we have responsibility for sharing learning from deaths in custody. This reply has been formulated in consultation with the Governor of HMP&YOI Rochester.

You have raised three matters of concern, and I will respond to them in the order in which you have raised them.

There was a failure to issue a Code Blue pursuant to both a local and national policy in circumstances where it was appropriate to do so

All night staff have been issued with a personal copy of Prison Service Instruction (PSI) 03/2013 Medical Emergency Response Codes and have each signed to say they understand the PSI and are fully aware of their responsibilities. A Notice to Staff setting out the policy has been issued and the remaining staff have been briefed at staff engagement sessions.

There was a lack of understanding as to what consequences flowed from the issuing of a Code Blue, namely that an ambulance would be summoned immediately

The Notice to Staff described above also explains that when a codes is used an ambulance will be called, and emphasises the importance of using the codes appropriately. Pocket-sized cards explaining the codes have been ordered and will be distributed to all staff.

There was a failure to consider or use a defibrillator when it was appropriate to do so and when one was available

The Notice to Staff described above also explains the process for the deployment of defibrillators and their location within the prison. A demonstration of the use of a defibrillator was provided during the July 2016 staff engagement session, and the Safer Custody team will follow this up so that all staff know when and how to use them.

You may also wish to be aware that relevant managers from HMP&YOI Rochester will be meeting colleagues from the South East Coastal Ambulance Service on 18 August to formalise a joint protocol for the response to emergencies within the prison.

I hope this provides assurance that the matters of concern that you have raised have been or are being addressed at HMP&YOI Rochester.

Yours sincerely



[REDACTED]
NOMS Equality, Rights and Decency Group

Kate Thomas
HM Assistant Governor
HM Governor's Court
Ardwick Park
Mill Street
Malden
ME11 5YE

Dear Ms Thomas

Reference is made to your report concerning the incident involving the death of Ronnie Cliffe on 1 October 2014 at HMP&YOI Rochester.

Thank you for your report addressed to the Governor of HMP&YOI Rochester concerning the incident involving the death of Mr Cliffe. Your report has been passed to Equality, Rights and Decency Group in NOMS, as we have responsibility for sharing learning from deaths in custody. This reply has been formulated in consultation with the Governor of HMP&YOI Rochester.

You have raised three matters of concern, and I will respond to them in the order in which you have raised them.

There was a failure to issue a Code Blue pursuant to both a local and national policy in circumstances where it was appropriate to do so.

All staff have been issued with a personal copy of Prison Service Instruction (PSI) 2520/13 Medical Emergency Response Codes and have each signed to say they understand the PSI and are fully aware of their responsibilities. A Notice to Staff setting out the policy has been issued and the remaining staff have been briefed at staff engagement sessions.

There was a lack of understanding as to what consequences flowed from the issuing of a Code Blue, namely that an ambulance would be summoned immediately.

The Notice to Staff described above also explains that when a code is used an ambulance will be called, and emphasises the importance of using the code appropriately. Pocket-sized cards explaining the code have been ordered and will be distributed to all staff.

There was a failure to consider or use a defibrillator when it was appropriate to do so and when one was available.

The Notice to Staff described above also explains the process for the deployment of defibrillators and their location within the prison. A demonstration of the use of a defibrillator was provided during the July 2015 staff engagement session, and the Safety Custody team will follow this up so that all staff know when and how to use them.