Investigation into the circumstances surrounding the death of a man in July 2010 at hospital whilst in the custody of HMP The Verne

Report by the Prisons and Probation Ombudsman for England and Wales

June 2011

This is the report of an investigation into the circumstances surrounding the death of a man, a prisoner at HMP The Verne. He died in July 2010 and was 50 years old. I would like to offer my sincere sympathy and condolences to his family for their loss. I am sorry that my report has been delayed and I regret any additional distress which this has caused.

The investigation was carried out on behalf of the Ombudsman by my colleague. I would like to thank the Governor of The Verne and her staff for their co-operation during the course of our enquiries.

The local Primary Care Trust (PCT) was commissioned to conduct a clinical review into the standard of healthcare he received whilst in custody at The Verne. They appointed a clinical reviewer and I would like to thank him for his review.

One of my family liaison officers contacted the man's family to inform them of our investigation and give them the opportunity to raise any issues about the care which he received whilst he was in custody.

He was found by a fellow prisoner at the bottom of a stairwell. Despite extensive first aid and resuscitation attempts, he died later that day in hospital. Sadly, the circumstances surrounding his death remain unclear. In common with the police investigation and the National Offender Management Services' health and safety investigation, I have been unable to determine the exact circumstances surrounding his death. I am sorry that this will inevitably cause additional distress to his family. The Coroner has recorded his death as being caused by multiple injuries due to blunt trauma.

I make five recommendations in my report regarding staffing levels at night, Close Circuit television and first aid matters.

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.

Thea Walton
Acting Deputy Prisons and Probation Ombudsman **June 2011**

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SUMMARY

1. The man was remanded into HMP Dorchester on 8 June 2009, charged with serious offences. He appeared in court three times before being granted bail on 17 August. His trial was scheduled for 9 December. He was found guilty of his offences and sentenced to five years imprisonment. He was received back into custody at Dorchester.

2. He was transferred to HMP The Verne on 5 January 2010. During his time at The Verne, he participated in an Alcohol Relapse Prevention Programme and applied to see the Counselling, Assessment, Referral, Advice Throughcare (CARATs) team. He was employed by the gardens party where he helped look after the prison grounds, and grew vegetables and herbs for the kitchen. He was said to be an "outstanding member of the team" by the Head of Horticulture.

3. During the early hours of the morning of 4 July, he was found by another prisoner, lying at the bottom of the stairs of A wing. It appeared that he had fallen from a height. The prisoner notified the member of staff, an Operational Support Grade (OSG), who was responsible for the wing during the night. The OSG went to the bottom of the stairs and, after seeing his condition, called for urgent assistance and for an ambulance to be called. Despite the extensive first aid efforts of both staff and paramedics, he died later that morning at hospital.

4. The police conducted an investigation into the circumstances surrounding his death. They concluded that there was no third party involvement and that the cause of his fall was unexplained. Health and safety representatives from the National Offender Management Service (NOMS) also conducted an investigation. They found no evidence to suggest that his fall was an accident and have also concluded that the incident cannot be explained. I have also been unable to establish a definite cause for his fall.

5. I make five recommendations as a result of this investigation. These concern the number of staff on duty at night, the provision of CCTV in the wings and several recommendations concerning first aid equipment and training.

THE INVESTIGATION PROCESS

6. One of my investigators opened the investigation at The Verne on 15 July 2010. She met senior prison managers, including the Deputy Governor, and took copies of prison documentation relating to him. Notices of the investigation were issued to staff and prisoners, inviting those who wished to provide information regarding his death to make themselves known to the investigator. No-one came forward in response to the notices. She visited the prison on 17 August, and 21 and 22 September, to interview staff and prisoners.

7. The investigator wrote to the Chief Executive of the local Primary Care Trust (PCT) to commission a clinical review. The PCT asked the clinical reviewer to carry out the review of the care received by him whilst he was at The Verne. He received a copy of the relevant medical documents upon which he based his findings.

8. My investigator contacted HM Coroner for Western Dorset District to inform him of the nature and scope of the investigation. Upon completion, a copy of my report will be sent to the Coroner to assist his enquiries into the man's death. He provided the investigator with a copy of the report of the post mortem following the death.

9. One of the Ombudsman's family liaison officers contacted the man's family at the beginning of the investigation. She informed them of the investigation and offered them the opportunity to raise any questions or concerns they would like addressed during the investigation. His sister raised the following issues:

    - Why was he out of his cell so early?
    - Is there any CCTV footage of the wing or stairwell?
    - What are the circumstances surrounding him going over the banister and falling 30 feet?
    - Was the emergency response adequate?

10. However, his mother told the family liaison officer that she was sure that her son's death was an accident. She described him as being happy in prison, said that he looked well and enjoyed his job working in the prison's gardens. She contrasted this with how he had looked before he went to prison when he had been drinking too much.

HMP THE VERNE

11. The Verne is a category C training prison for adult men on the Isle of Portland, Dorset. It holds up to 607 prisoners who are mainly life sentenced prisoners or those who have received a determinate sentence (where the number of years imprisonment to be served is decided by the sentencing judge). Foreign national prisoners form a large part of the population.

12. Inside the secure perimeter walls of the prison, there is minimal physical security and prisoners are able to move freely around the prison. For this reason, only those prisoners who meet the strict reception criteria are accepted. Suitable prisoners, among other factors, must:

    - be 25 years of age or older
    - have at least nine months of their sentence left to serve
    - have no history of escape or attempted escape
    - have no history of racism
    - have no significant history of prison drug trafficking or dealing
    - not require intensive psychiatric intervention
    - not be assessed as posing a high risk to other prisoners.

13. The man's cell was situated in A wing, which is one of six purpose built house blocks. Each wing can accommodate a maximum of 86 prisoners on three floors, and most prisoners occupy single cells. All the prisoners have keys to their rooms and A1 wing, where he lived, only accommodates enhanced level prisoners. (Under the Incentives and Earned Privileges scheme, prisoners are assessed according to a number of factors, and rated as basic, standard or enhanced. Enhanced prisoners receive privileges compared to other prisoners, depending on the scheme run in the prison.) Prisoners are required to be in their rooms by 11.30pm until 6.30am, but otherwise they are able to move around the wing freely at all other times.

14. At night one Operational Support Grade (OSG) has responsibility for the entire wing. When not carrying out his roll checks, he is located in the ground floor wing office.

15. There is no 24 hour healthcare at the prison, and in the case of an emergency outside of normal working hours, a call is made to an on-call doctor. Dorset Community Health Services (DCHS) provides healthcare between 9.00am and 5.00pm, seven days a week. Out of hours provision is sub-contracted to South West Ambulance Service Trust who also provide the out of hours emergency response.

16. The National Offender Management Service (NOMS) publishes quarterly performance ratings for all prisons in England and Wales. The ratings are based on a set framework and prisons can be rated from one to four (with four indicating 'exceptional' performance). The Verne has achieved a rating of three ('good' performance) for the last four published quarters.

Previous investigations by the Prisons and Probation Ombudsman

17. My office has investigated six previous deaths at The Verne. Although there are no similarities between the circumstances of the man's death and the others I have investigated, I have previously made recommendations about the provision of first aid training. The last recommendation on this issue, however, was made after he had died. I have also made a recommendation that staff on nights should be trained to use a defibrillator, and that more defibrillators should be provided. Although this recommendation was partially accepted in January 2010, I make a similar recommendation as a result of this investigation. A response to the draft report from Dorset Community Health Services noted that an additional defibrillator has been purchased, however the Governor has said that the Prison Officers Association (POA) would not support prison officers in its use, as they were not medically qualified. They also said that the first response should be to call the emergency services.

HM Chief Inspector of Prisons (HMCIP)

18. The most recent available inspection report by HMCIP relates to a full announced inspection of the prison conducted in August 2007. (HMCIP inspected The Verne again in 2010 but the report is not yet available.) The then Chief Inspector noted the good relationships between staff and prisoners and reported that earlier concerns about safety had been "largely addressed". However, she said that violence reduction and safer custody policies were not sufficiently robust.

19. Inspectors found that the violence reduction strategy did not meet the needs of the population and there were no interventions to encourage bullies to confront their behaviour. However, the inspection found little evidence of violence at The Verne, and prisoners said they felt safe there.

Independent Monitoring Board (IMB)

20. Each prison in England and Wales is monitored by an independent board of volunteers drawn from the local community. Members of the Board have access to every part of the prison and all prisoners held there. The Board must produce an annual report, the latest available for The Verne covering the period May 2009 to May 2010.

21. The IMB reported on "great improvements" in safer custody in their 2009 report. However, during the following year's report they noted that:

> "… the optimism voiced by the IMB in the 2009 report has unfortunately failed to persist throughout the year. The appointment of a non-uniform Safer Custody Co-ordinator, whose post was meant to be safeguarded (i.e. the person doing the job was not meant to be moved to another area in the event of staff shortages/changes) did not last long."

22. The IMB also reported that "there have not been many anti-bullying files opened in recent months, and there are some concerns that not all incidents are being reported – and if not why not".

Health and Safety (H&S)

23. A member of the IMB attends quarterly Health and Safety meetings. There were no serious incidents in the prison during the year. The IMB noted that "the H&S department at The Verne, which includes a full time Fire Officer and part time clerk, are all very committed".

24. Officers and civilian staff are able to attend regular internal courses on Health and Safety. The majority of the IMB members have attended both a health and safety and manual-handling course.

25. Due to the age of some buildings, which date back to about 1873, some areas continue to be damp and require de-humidifying on a regular basis. These areas (which are known as casements) house education and library facilities and the Kainos residential wing (which is used as a therapeutic community) as well as other offices. There are other areas which are not fully utilised because of Health and Safety legislation.

KEY FINDINGS

26. The man was remanded into custody at HMP Dorchester on 8 June 2009, charged with serious offences. He had previously come into contact with the legal system on a number of occasions, for various offences, and had served a custodial sentence 18 years previously.

27. During his first reception health screen on arrival at Dorchester, he stated that he was a smoker, drunk a bottle of vodka a day, suffered from boils on his groin, was allergic to amoxicillin (an anti-biotic) and had high cholesterol. Prison Doctor A prescribed simvastatin (a drug used to control elevated cholesterol) and asprin for his high cholesterol and also consented to him having his own flip flop sandals sent in (although the reason for this is not clear).

28. On 14 July, he attended an appointment with Prison Doctor A about the boils on his groin. He was prescribed Betadine spay (an antiseptic spray) and advised that, if this did not help, he should return to be prescribed antibiotics. On 17 July, he went back to healthcare and was examined by Prison Doctor B, who prescribed antibiotics and an anti-fungal cream.

29. He attended three court appearances during June and July. He was granted bail on 5 August, on the conditions that he surrendered his passport, adhered to a curfew, wore an electronic tag and presented himself to a police station every day. He was also not allowed to enter Dorset, except for the purposes of his court appearances.

30. On 9 December, he was found guilty of his offences and was sentenced to five years imprisonment. He was received back into custody at Dorchester, where he had another first reception health screen. It was noted in his medical record that he had no signs of depression and his blood pressure was elevated. Prison Doctor A also re-prescribed simvastatin and aspirin. His blood pressure was then monitored weekly and recorded in his medical record.

31. He transferred to The Verne on 5 January 2010. He received another first reception health screen and it was recorded in his medical record that he was suitable for cell sharing (a cell sharing risk assessment was conducted). However, he was allocated a single cell as he snored heavily.

32. The next day, he had a review with Nurse A, a mental health nurse. She recorded that he appeared calm and had no issues at present. During his review, he said that he had smoked cannabis in the last month and so she referred him to the drugs service.

33. He saw a Counselling, Assessment, Referral, Advice and Throughcare (CARATs) worker on 26 January, and underwent an assessment. He scored medium to high on the alcohol audit and was put forward for the Alcohol Relapse Prevention Group Programme. He completed all ten sessions during March and April and his report was sent to the Offender Management Unit (OMU).

34. During his time at The Verne, he continued to suffer from persistent boils on his groin, on his neck and under his armpit. He was prescribed various antibiotics and anti-inflammatory creams to treat the boils, and also had them lanced.

35. On 19 March, he saw Prison Doctor C regarding the boils on his groin. It is recorded in his medical record that he said that he had been suffering with "dribbling" after urination for the previous eighteen months. The doctor referred him to a urology consultant. An appointment was made for 24 June, but he did not attend. There is no information in the prison documentation to explain why he did not attend this appointment.

36. He saw Prison Doctor D on 19 April to discuss his high cholesterol level. He said that he would prefer to try and diet and exercise as opposed to taking tablets to reduce his cholesterol. The doctor referred him to the gym for an appropriate exercise regime. He attended the gym in the mornings and his weight was monitored.

37. He referred himself to see the CARATs team on 18 May. He was seen by a CARATs worker on 26 May for his assessment. During his assessment, he stated that he had a history of drug and alcohol abuse, but that he had undergone a Twelve Step drug treatment programme in the community and had remained drug free for ten years. He had started drinking which had led to snorting cocaine. She recorded that he was unsure whether he to do a CARATs or the Twelve Step programme. He was also due in court soon and was unsure what prison he would be coming back to. He stated that he would refer himself back to CARATs once he was settled.

38. On 30 June, he was examined by Prison Doctor D as he was experiencing back pain. The doctor prescribed an analgesic (pain relieving) cream and he passed a sick note to the wing officers to be excused from work. During an interview with the investigator, the Head of Horticulture, said:

> "The week prior to his death it was a bit strange to be told he's gone sick but sort of two to three days prior to that he did mention to me … that he'd got some worry about some Confiscation Order and hearing."

He said that this was unusual as the man would normally talk to him or his colleague about his affairs. However, Prisoner A, who had the same legal representatives as him, said that he did not think he had been that concerned about the Confiscation Order or returning to Dorchester.

39. He was due to go to court on 2 July for the confiscation hearing. Despite telling the Head of Horticulture that he was worried about going to court (as he did not know which prison he would go back to and he wanted to return to The Verne, and also that he might get an extended sentence), his friend said he did not think he was overly concerned about the hearing. The court appearance was postponed and a new date had not been arranged before he died.

40. On 3 July, he had a visit from his girlfriend. The visit went well and he was said to have been in good sprits afterwards. His girlfriend told the police after his

death that the visit had been entirely pleasant and friendly. There had been no suggestion of ill feeling between them or within his family, and he had not mentioned getting any bad news.

41. That evening, as it was his birthday, some of the prisoners on A wing arranged to have a party. He made some sandwiches and a fruit salad. As a World Cup football match was being played that night, some prisoners (including him) sat around eating tea and watching the match. Prisoner A explained that four or five prisoners had their doors open and they moved freely from one room to another enjoying the evening. At about 10.00pm, after the match, he said that all the prisoners returned to their own rooms and he did not see or hear from him again that night.

4 July

42. The OSG was the member of staff on duty overnight on A wing from 9.00pm on 3 July to 8.00am on 4 July. He was responsible for approximately 80 prisoners. He said during his interview with the investigator that his main job was to patrol the wing at half hour intervals. He completed his last round of checks at 5.58am. (Officers are required to check in electronically at various points across the wing during the night, confirming they were there and the time. At the end of a shift an electronic print out is generated. This is known as pegging.) The wing rule states that prisoners should return to their own rooms by 11.30pm. However, he confirmed that there are no observation panels on the prisoners' doors and he does not go into any rooms to check on the prisoners. In between patrols, he remains in a locked office on the ground floor.

43. He told my investigator that the wings had been quiet as normal that evening. He had walked the length of the wing on the second landing (which is where the man's cell was located) and did not see anybody, but he had heard the movement of early risers and a shower running at approximately 6.00am. He then returned to the wing office. He said that he heard a thud about 15 minutes later, and possibly a noise which he thought was made by a plastic bin, but did not go to investigate as he did not think it was anything unusual.

44. Around 6.25am, Prisoner B had got up to go to the toilet on the first floor. Prisoners are permitted to leave their rooms after 6.30am, but many are up and about earlier than that. The investigator was told that the man was an early riser, but otherwise it is not clear whether there was a specific reason why he was out of his cell at that time.

45. Whilst the prisoner was in the toilet, he heard loud breathing. He followed the direction of the sound out on to the landing and looked over the railing, where he saw a prisoner, later identified as the man, lying at the bottom of the stairs.

46. At this point, Prisoner C was coming down the stairs from the second landing. He too had heard heavy breathing and he met the other prisoner on the first landing. Prisoner B pointed out the man, who was lying on his back on the floor at the bottom of the stairs. He asked the other prisoner to inform the OSG, and then went to the bottom of the stairs to see if he could help.

47. Prisoner C knocked on the wing office door and informed the OSG that he had come down for some hot water and that someone was lying on the floor at the bottom of the stairs. He told the OSG that the man was panting and he assumed that he was injured, but did not know for sure and could not see any blood at this point. The OSG asked if he had seen what had happened to which the prisoner shook his head.

48. The OSG went to the bottom of the stairwell and found the man lying flat on his back with one leg raised at the knee. He observed that he was groaning, had a head wound at back of his head which was bleeding, and was breathing heavily. He called an urgent message over the radio, requesting assistance and an ambulance. He made the call at approximately 6.25am.

49. Another OSG who was located in the control room dialled '999' to request an ambulance and informed them of the situation. At this time, two officers and a Senior Officer (SO) had heard the emergency call over the radio and arrived at the scene (these were officers managing the prison during the night). Officer A recalled at interview that the man had blood at the left side of the back of his head, which was pooled around his head. He ran to the wing office to get the first aid kit and assisted the OSG administer first aid. (The officer had attained his first aid certificate the week before and the OSG had last attended a course three years earlier.) The officer applied a dressing to his head to try and stem the bleeding. At this point, he appeared unconscious, had one eye open and one eye closed and was breathing slowly and deeply. He did not move at all.

50. The contents of the first aid kit from the office were inadequate for the officer's needs, so he asked Officer B to get more dressings to help stop the bleeding. The officer then ran around the wings to take dressings from the first aid boxes. Officer C, who had also heard the emergency call and ran to the scene, then ran to the segregation unit to get some blankets to cover him and keep him warm. Officer A did not ask anyone to collect the single defibrillator in the prison as nobody, apart from healthcare staff, knew how to use it. He was still breathing at this time. DCHS said in response to this report that there are two defibrillators based at the prison, one in healthcare and one in the segregation unit. Also that first aid boxes are the responsibility of the prison to stock, although DCHS would be happy to advise on the contents.

51. The officers were unable to identify him and the SO went on to the wing and asked a prisoner to identify him. The SO returned to the foot of the stairs. She became increasingly worried that he might die as he was foaming at the mouth and his eyes had rolled back. The SO spoke to the ambulance control at 6.37am and updated them about the situation. The ambulance control advised that the officers should continue talking to him, keep a compression on his head and ensure that his mouth was clear from obstruction until the paramedics arrived. The officers followed this advice and three paramedics arrived at A wing at 6.44am.

52. Officer C sealed off the wing with incident tape. He looked around the wings to see if he could find the prisoner who had alerted the OSG. While doing this, he

saw his identification card and keys just inside his cell, and closed the door. Meanwhile, the SO requested a camera from security so that she could take photographs of the scene. At interview she told the investigator that not having access to a camera at night (apart from going through Security staff) was inconvenient, because she wanted to take pictures of the immediate scene. It was noted that he had been wearing flip flop sandals. Each sandal was found on a different stair close to where he was discovered.

53. The paramedics took over from the OSG and Officer A in administering first aid to him and they prepared him to be transferred to hospital. As the paramedics were putting him on the board to be taken to the ambulance, they noticed a dent in his spine and bruising on his shoulder and on his hip. During this time, the SO arranged an escort to accompany him to hospital and informed the duty Governor of the incident. He was taken to hospital at 7.20am, escorted by two officers. No restraints were used at any time.

54. The ambulance arrived at the hospital at approximately 7.45am. Officer D stated during his interview with the investigator that on arrival there was "a team ready to go … people worked on him straight away". At 7.50am, hospital staff asked for details of his medical information. Officer E contacted the prison and a nurse went to healthcare where she telephoned the hospital to give them the relevant details.

55. The duty governor that day held a hot debrief meeting with the staff involved in the incident before they went off duty. He discussed the incident to try and establish the circumstances. He also asked if the staff were alright or whether they needed the support of the care team. Officers talked about their involvement in the morning's incident and highlighted any concerns they had with the emergency response and the resources that were available. Officer A mentioned the lack of first aid equipment, in particular absorbent pads, on the wing.

56. Despite the extensive first aid efforts of both prison and medical staff, the man died at 8.25am. During his interview, Officer D stated that

> "… the doctor came out … then informed us that he had died actually not long after we'd actually arrived there but they'd obviously continued to work on him for approximately three quarters of an hour."

The officer then telephoned the prison from the hospital and confirmed that he had died.

57. At 8.43am, the duty governor informed the chaplain that the man had died. He attempted to telephone the man's mother, but was unable to reach her on the telephone and so left a message on her answer machine informing her that there had been an incident. He passed the mother's details to the chaplain and asked him to contact her and inform her about her son's death the incident. The chaplain was also unable to contact her as she was out on a day trip. He spoke with the Roman Catholic Minister of the area where she lived in London who offered to assist if required.

58. The police arrived at the prison at 9.25am and went to the stairwell on A1 wing. As the incident was unexplained and had not been witnessed by anyone, the police treated his fall as suspicious. A Scene of Crime Officer arrived and began to evaluate the scene, taking photographs as evidence and going to the third floor to see if there was any obvious explanation as to how he had fallen over the rail. The police officers also began to take statements from the staff who responded to the incident.

59. The duty governor contacted HMP Pentonville at 11.14am, to ask for assistance to contact the man's mother. Another prisoner at The Verne telephoned the man's girlfriend in the meantime and told her that he had been involved in an incident. The man's girlfriend and sister then began to telephone the prison to ask for more information. The duty governor confirmed that there had been an incident, but was unable to tell them any further details as the next of kin had still not been informed. The deputy governor contacted the duty governor at HMP Pentonville again at 3.30pm to ask them to contact the man's mother.

60. At 3.40pm, the deputy governor began trying to contact the man's sister. He managed to gain contact with her at 5.00pm and formally told her of her brother's death. It is unclear why this took so long, given that she had already contacted the prison earlier that day. The Governor of HMP Pentonville telephoned the deputy governor at 6.00pm to confirm that his staff had spoken to all of the man's relatives and next of kin. An officer was appointed as the prison's family liaison officer until another family liaison officer returned from leave. The officer liaised with the family regarding any concerns they had and the procedure for returning his property.

61. In the meantime, there appeared to be some confusion amongst prisoners on A wing about what had happened to him. Eventually, an officer spoke to a group of prisoners to explain what had happened and put up notices informing them that he had died. All prisoners who were being monitored through the Assessment, Care in Custody and Teamwork support procedures (ACCT, which ensures that prisoners at risk of harming themselves are properly monitored and supported) were reviewed. All the prisoners were reminded of the services of Listeners (other prisoners who are trained to speak and listen to others in distress) and Samaritans.

62. A critical incident debrief was held for staff about three weeks after he died.

63. The post-mortem was held on 5 July. It concluded that there was evidence that he had sustained a fractured skull, multiple rib injuries and a fractured pelvis. There was also haemorrhaging around both renal pelves (a part of the ureter in the kidney) and within both thoracic (chest) cavities. It was determined that the likely cause of death was multiple injuries due to blunt trauma.

64. Another officer took over the role of prison family liaison officer on 22 July when he returned from annual leave. He telephoned the funeral director who told him that the funeral had taken place on 20 July. On 2 August, my investigator was told by the Ombudsman's family liaison officer that the prison had paid for

transport to the funeral director but not for the funeral. After speaking with the investigator, the prison family liaison officer spoke to the Governor and Deputy Governor about this matter. They immediately agreed that the funeral expenses would be paid for by the prison once the funeral director submitted an invoice which was completed the next day.

65. A Detective Chief Inspector (DCI) led an investigation into the circumstances of the man's death. She was satisfied that there were no suspicious circumstances surrounding the incident and there was no evidence or suggestion of any third party involvement or foul play. She concluded that the cause of his fall in the stairwell was unexplained.

66. The NOMS South West Regional Health, Safety and Fire Safety Advisor and the Health and Safety Advisor at The Verne conducted a health and safety investigation into the circumstances of the man's fall. They looked at various prison and wing documentation, including wing logs, cleaning procedures, photographs and staff statements as part of their investigation as well as conducting a thorough evaluation of the area that he fell. The health and safety investigation concluded that

> "We have not found any evidence that would lead us to conclude that his death was as a result of an accident as we could not find a reasonable cause or failure that could lead to the same."

67. A clinical reviewer carried out the clinical review for the man. He was also unable to form an opinion as to why he had died. However, he determined that he had received good care whilst he was in prison.

ISSUES

Night time staffing levels

68. It is of some concern to me that only one Operation Support Grade is on duty on A wing of a night, with responsibility for approximately 80 prisoners. My investigator spoke to the Head of Residence about this, and he said that the prisoners on the wing are all risk assessed. Amongst other things they have to be aged over 25 years, have more than nine months to serve and be assessed as a low escape risk.

69. Despite the risk assessment, I am concerned that the OSG on night duty locks himself in the ground floor office, only leaving the office to conduct his checks. Although the wing rule is that all prisoners should be in their own room by 11.30pm, the OSG has no way of checking this as they do not open the doors to see in to the rooms, and the doors do not have observation panels. In essence, as all prisoners have keys to their rooms, they can effectively move about as they choose. I understand that these arrangements are the same for other wings, and that no incidents of a similar nature have occurred. However, this casts doubt on whether this is a safe environment for either prisoners or staff.

The Governor should ensure that a review into night staffing levels is carried out immediately to ensure that both prisoners and staff are safe.

Closed circuit television (CCTV)

70. Following on from the previous issue, the absence of CCTV on A wing compounds the risk of an incident occurring without detection. If the current staffing level remains as it is (an OSG who is usually locked in an office), I suggest that CCTV would give both prisoners and staff extra protection. This is particularly true of areas that are difficult to monitor, such as stairwells. It is perhaps an obvious point, but if CCTV had been installed, then the man's death could at least have been explained, if not prevented.

The Governor should consider installing CCTV on the wings.

First aid equipment and training

71. Staff who administered first aid to the man commented on the lack of equipment (for example, absorbent pads and bandages) in the boxes located on the wing. They had to run to other locations to find suitable items to assist the first-aiders. It is clearly important that those attempting to give first aid have as much of the correct equipment as possible. While it is unlikely, given the injuries which he suffered in the fall, that he would have survived even with adequate supplies being immediately to hand, in other circumstances this might be vital.

The Governor should ensure that first aid boxes are adequately stocked at all times and also that other items (which cannot fit in the box) are available on the wing.

72. The OSG, who was on duty on A Wing, said that he had received first aid training in 2009. However, the senior officer said that all OSGs who work nights received part day training over three years ago. I do not think that this is unacceptable given that an OSG is the sole member of staff on duty at night, and given that no healthcare staff are on duty during the night. Whilst I accept that the OSG will radio through an emergency call to colleagues, they will inevitably be the first member of staff at the scene and I believe that they should have an up to date first aid qualification. It also seems that Officer A was the only officer who responded to the emergency who had current first aid training.

The Governor should ensure that a cross section of all staff, and all the staff who work at night, should have an up to date first aid qualification.

Although in this case a defibrillator was not needed as the man was still breathing, I am concerned to learn that there is only one machine in the prison (DCHS have since said there are two machines in the prison) and only the healthcare staff know how to operate it. I have raised this matter in a recommendation following a previous investigation and I am concerned that this has still not been satisfactorily addressed. Given the absence of 24 hour healthcare cover, it is important that a cross section of staff, particularly those who work at night, are able to use the defibrillator.

The Governor should ensure that a cross section of staff, but in particular those who work night duty, are trained to use the prison's defibrillator.

Delay in informing the man's family

73. It is clear to me that the prison made every effort to contact the man's mother, but was unable to do so as she was away for the day. I can see from the prison documentation that he had only named his mother as his next of kin. However, as his mother was unavailable and his sister had rung the prison (after being telephoned by a prisoner and told what had happened), I think that it would have been sensible for prison staff to confirm her identity and disclose what had happened. I make no formal recommendation in this regard, but would prefer to see a more pragmatic approach to difficult situations such as these.

Funeral costs

74. My investigator was informed by the prison's liaison officer that the prison did not initially offer to pay for the man's funeral costs, although they had agreed to pay for him to be taken from the hospital to the funeral director. This was eventually rectified once my investigator made the Governor aware of the omission and the Governor agreed to contribute towards the funeral expenses. Prison Service Order (PSO) 2710 (Follow up to deaths in custody) states that the prison should offer to pay reasonable funeral expenses. The PSO considers that £3,000 is a reasonable amount. I make no formal recommendation but take the opportunity to remind the Governor of his responsibility.

Health and Safety investigation

75. The Health and Safety investigation concluded that the prison had systems in place for maintaining the floors, stairs and handrail in a safe condition and that the handrail was at the requisite height prescribed in the regulations. Also the floors and stairs were kept clean and staff checked that the cleaning was carried out properly.

76. There was no evidence to suggest that there were any trip hazards, and no witness evidence to the incident itself. There was also no evidence that the man had any disability or medical condition which could have caused him to fall.

77. The report concluded that there was no evidence to conclude that his death was due to an accident. Neither could the investigation find a reasonable cause or failure which would suggest this to be the case.

Aftercare for staff and prisoners

78. Some of the staff who were interviewed by the investigator were concerned that they had been overlooked and they were not invited to either the hot debrief or the critical incident debrief. In particular, the Head of Horticulture said that he felt let down that he did not get the opportunity to speak to anybody about the man's death. Similarly, prisoners on A wing who were concerned about him, or were friends with him, felt they could have been told earlier about what had happened. However, it was good practice that all those receiving ACCT suppport were reviewed and prisoners were given access to a chaplain and to the Listeners and Samaritans should they need it.

Access to cameras

79. The night duty senior officer said that it would be useful to have immediate access to a camera in case of emergency situations. As I understand it, the current arrangement is that a member of security staff is asked to supply the camera from the Security Department. Although I make no formal recommendation here, I would ask that the Governor considers what resources should be available to the night staff.

CONCLUSION

80. It is with regret that the Ombudsman's investigation, along with the police and Health and Safety investigations, has been unable to establish the circumstances which led to the man's death. There is no evidence to suggest, in the weeks leading up to his death, that he might have intended to take his own life. Equally, it is not clear why he was awake at that time or why he was in the stairwell. Although there is a possibility that he was concerned about a Confiscation Order hearing, which he mentioned to the Head of Horticulture, another prisoner and friend said that this was not the case. In any event the hearing was postponed and another date had not been arranged.

81. The Health and Safety report concluded that the stair rail was in a safe condition and at the prescribed height (1.10 metres high), that there was no evidence of any trip hazards or a slippery floor and he did not appear to have had a disability or medical condition which would have increased his risk of falling. Although it appears that he was wearing his flip-flop sandals when he fell, there is no evidence to suggest that this played a part in his fall.

82. The police investigation, conducted shortly after his fall was reported, concluded that there was no evidence of anyone else being involved in what happened.

83. Although I hope that I have answered most of the questions raised by his family, I am sorry that I, along with the police and NOMS, have been unable to shed any more light on what happened to him on the morning of 4 July. They will have the opportunity to ask more questions at the Coroner's inquest.

RECOMMENDATIONS

1. The Governor should ensure that a review into night staffing levels is carried out immediately to ensure that both staff and prisoners are safe.

   This recommendation was accepted by the prison. Action by 31 August 2011.

2. The Governor should consider installing CCTV on the wings.

   This recommendation was partially accepted by the prison. Estimated cost to be prepared by the Estates Manager and bid compiled if appropriate/feasible. Action by 31 August 2011

3. The Governor should ensure that first aid boxes are adequately stocked at all times and also that other items (which can not fit in the box) are available on the wing.

   This recommendation was partially accepted. A supply of additional dressings/absorbent pads to be provided to wings as recommended. Action by 31 August 2011.

4. The Governor should ensure that a cross section of all staff, and all staff who work at night, should have an up to date first aid qualification**.**

   This recommendation was accepted by the prison. All night staff are now trained.

5. The Governor should ensure that a cross section of staff, but in particular those who work night duty, are trained to use the prison's defibrillator.

   This recommendation was not accepted by the prison. A National Agreement and Union Acceptance would be required. At present no non-medical personnel are trained and there are no plans to change this.