

**Investigation into the circumstances surrounding the
death of a man in November 2005 whilst in the
custody
of HMP Risley**

**Report by the Prisons and Probation Ombudsman for
England and Wales**

July 2007

This is the report of an investigation into the death of a man who was discovered lying on the floor of a landing in a residential unit at HMP Risley in November 2005. He had sustained serious head injuries. He died in hospital without regaining consciousness. He was 41 years old.

I offer my sincere condolences to his family and to all those touched by the loss of his life.

One of my Family Liaison Officers and an investigator met the man's aunt to learn of the particular concerns the family had about his death. That it should have occurred in such violent circumstances must be particularly painful for his family. I hope that this report answers many of their questions although it will not lessen their grief.

The investigation was undertaken on my behalf by two of my Senior Investigators. The Assistant Director of Health Standards at Warrington Primary Care Trust undertook a clinical review of the care the man received and I am grateful for her comprehensive report.

I also wish to acknowledge the assistance I have received from Cheshire Police. I express my thanks too to the Governor of Risley and his staff for their help and co-operation.

The responsibility for discovering how the man came to receive his injuries and who perpetrated them has rested with the police rather than with my office. My investigation and this report, which have inevitably been delayed because of the primacy of the police inquiries and a recently concluded criminal trial, focus on how Risley handled the discovery of the man and the aftermath to these sad events.

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Prisons and Probation Ombudsman

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SUMMARY

On 8 December 2003, the man was convicted of several offences of burglary. In January 2004, he was sentenced to four years imprisonment. It was not his first time in custody. He spent short periods in Altcourse, Shrewsbury and Blakenhurst before being transferred to HMP Risley on 25 August 2004. There was little concern about his conduct and no current security information on him.

On the morning of Sunday 13 November 2005, a prisoner approached two officers in a spur office on Risley's C wing to say there was a prisoner on the ground floor landing of the south spur who was "in a bad way". The prisoner had seen the man lying unconscious and placed him in the recovery position before seeking staff assistance.

The officers immediately made their way to the landing. It was evident that the man was suffering from serious head and facial injuries. One officer called over his radio for urgent medical assistance from healthcare staff, the other went to fetch the wing senior officer.

Healthcare staff arrived and monitored the man's condition. An ambulance was called at 10.20am. As the man was already in the recovery position, had a strong and steady pulse and the ambulance had been requested, the healthcare staff did not initiate any medical interventions. However, the ambulance did not arrive until half an hour after it had been called.

After the discovery of the man's injuries, the prisoners on C wing remained unlocked. They were able to go on to the outside exercise yard, attend a gym class or go to church. Many of those who stayed on the wing remained on the ground floor and watched staff tending to the man. Others went to the upper landings and looked over the railings to observe what was happening. Some shouted out their impatience at the non-appearance of the ambulance. In order to create access for the paramedics, prisoners were given the choice of being locked in their cells or going to the north spur of the wing. Some were locked in their cells, but most chose to go to the other side.

At 10:56am, an alarm bell was activated on C wing north spur. There appeared to be fighting and disorder taking place involving up to 100 prisoners. Chairs, snooker cues and mop wringers were being thrown. When the disorder broke out, there were no officers supervising the north spur. At least one prisoner was assaulted by others and was rescued by three staff who threatened to use their staves if the prisoners did not withdraw. The prisoners immediately backed down and the officers did not use their staves. The violence was between prisoners rather than aimed at staff. Order was restored within minutes and prisoners were eventually locked in their own cells. A second prisoner was found to have been injured and both were taken to the healthcare centre for treatment. Their injuries were not life-threatening.

The man was taken to the local hospital at 11:35am. He was then transferred after surgery to a specialist unit at another hospital.

At lunchtime on 13 November, prisoners were allowed to collect their lunch a few at a time. Extra staff were on duty given what had occurred during the morning. Nevertheless, a prisoner entered the south servery and attacked one of the servery workers. The assailant was in turn pursued by another prisoner.

The Command Suite was opened by the duty governor to enable him to manage the unfolding events. However, it was only in the afternoon that it was realised that the police had not been called. They eventually attended at 3:20pm.

The man died 4 days later without regaining consciousness.

The day after his death, the Director General of the Prison Service wrote to the man's aunt to express his sympathy. His letter said that the police had been called immediately to the prison after the assault. The family felt that they had been given misinformation as the police had not in fact been contacted until four hours after the man was found.

Risley did not appoint a Family Liaison Officer until after the man's death. Coupled with the perceived misinformation in the Director-General's letter, this led the man's aunt to conclude that she did not wish to have any further contact with the Prison Service although a prison Chaplain did remain in touch with the family.

A clinical review of the care the man received before and after he was attacked was carried out by a Medical Practitioner from Warrington Primary Care Trust. She concluded that the care of the man after he had been discovered was not as good as it might have been. She has made a number of recommendations concerning the organisation of healthcare at Risley and the initial response of healthcare staff when the man was discovered.

My report includes several recommendations concerning the arrangements for prison-police liaison, family liaison and the management of serious incidents at Risley. However, it recognises the efforts Risley made to acknowledge the seriousness of the man's death and to mark his passing.

THE INVESTIGATION PROCESS

1. My investigators visited Risley twice. They were given access to the man's prison records including his medical record, statements from staff and other documentation concerning the events on the day that he was assaulted.
2. My investigators met with the Detective Chief Inspector and the Detective Inspector from Cheshire Police to agree a protocol for the investigation of the man's death and sharing information. I agreed to delay the start of my investigation until the police had completed their criminal investigation.
3. Notices to staff and prisoners announcing the investigation were displayed around the prison. I was contacted by one prisoner who wished to raise his concerns about the potential for violence at Risley. My investigators met representatives from the Independent Monitoring Board and the Prison Officers' Association to offer them the opportunity to raise relevant issues.
4. The man's family were offered, and accepted, the opportunity to contribute towards the investigation process. One of my Family Liaison Officers visited the man's aunt with one of the investigators to discuss the issues she wished to raise. Regrettably, a few of the issues raised by the man's aunt have not been addressed as they fell outside of my remit and were matters for the criminal investigation.
5. A clinical review was requested from Warrington Primary Care Trust. I am grateful to the Assistant Director of Health Standards, for undertaking this comprehensive review in a timely manner.
6. HM Coroner for Cheshire was contacted to inform him of the nature and scope of my investigation and to request a copy of the post-mortem report. A copy of my report has been given to the Coroner.
7. Following the conclusion of the recent criminal trial, a copy of the draft report was provided to the Prison Service under our policy of advanced disclosure where the actions of identifiable members of staff have been criticised. The Prison Service's response to the adverse comment made in the clinical review is contained in the body of this report.

HMP RISLEY

8. HMP Risley was opened in 1964. It has had various roles since then, but has been a medium security category C prison for male adults since 2000. It holds up to 1,073 sentenced prisoners in mostly single cell accommodation. Much of the prison has been rebuilt and modernised in recent years. The redevelopment programme is still in progress.
9. C wing holds 197 prisoners in mostly single cells. It consists of a north and a south spur – each three storeys high, linked at each level by a gated corridor with staff offices. Each landing has recreation areas for prisoners to socialise, bathing facilities and telephones. At the time of the man's death, C wing prisoners were able to move freely between both spurs, using the ground floor access, during association times.
10. My investigators met with the Governor. He said that historically C wing had been one of the most difficult to manage as it had no particular admission criteria, and accepted prisoners who did not need or want the specific support provided in other wings (e.g. for drug misuse, or for sexual offending). He said that, nevertheless, staff-prisoner relationships had improved in the months leading up to the man's death and there had been no particular concerns about its management.
11. Her Majesty's Inspectorate of Prisons carried out an unannounced follow-up inspection of Risley in May 2003. In the introduction to the inspection report, there were comments about the treatment of vulnerable prisoners (predominately, but not exclusively sex offenders). The report stated:

“There was considerable anecdotal evidence, from both staff and prisoners, of verbal and physical abuse, yet the establishment was not monitoring or analysing to what extent, where and why this took place. As a consequence there were effectively separate workshops as vulnerable prisoners self-segregated, because of their fears about their safety.”

It went on:

“Anti-bullying processes were under developed and there was no investigation of the cause or nature of injuries, assaults and self harm. This reflects a more general finding in the prison as a whole.”
12. Risley was re-inspected in February 2006. The report of the inspection acknowledged that safety remained a significant concern, especially in the light of the man's death. Thirty per cent of prisoners reported to the inspectors that they had felt unsafe at some point. The inspectorate team was particularly worried by the lack of visible staffing. It concluded:

“This is the second consecutive report that has raised concerns about safety at Risley. Risley is still not a sufficiently safe prison and more focus is required on violence reduction, supported by a more proactive approach to prisoner supervision and a continued emphasis on combating illegal drugs”.

KEY EVENTS

The events of 13 November 2005

13. On 13 November, there were six officers and one senior officer (SO) on duty on C wing, the minimum staffing level for that wing for a Sunday morning. Five of the officers normally worked on C wing. The sixth officer was cross-deployed from another area so that the wing could be unlocked. The wing SO described the start of the day as “a ... very quiet morning, nothing out of the ordinary ... just a very, very ordinary day ...”
14. The normal routine for a Sunday morning is for prisoners to be unlocked for breakfast at 8:00am. An optional cooked breakfast is served, then prisoners have free time until midday to socialise on the wing, remain in their cells or use their time as they wish. Activities on a Sunday include the option of access to an outdoor exercise yard from about 9:30am, Roman Catholic church at 10:15am, and gym (also at 10:15am) for those who have pre-booked. Lunch is served at about 11:45am and then prisoners are normally locked up at 12:15pm for a roll check.
15. Three staff were detailed to work on the north spur and three officers performed similar roles on the south spur. At about 8:05am, the man was unlocked from cell C2-07 south by the first wing officer. In his police statement, he said that the man was up and dressed, waiting to come out of his cell when the officer opened his door. He noted that, whilst the man had seemed a bit down, a bit quieter and unshaven the day before, on 13 November he appeared “back to normal, he’d shaved and was of a smarter appearance.” He was the only member of staff who recalled having direct contact with the man that morning.
16. After breakfast, the second wing officer and the sixth officer went to the outside exercise yard to make preparations for the start of the exercise period. Although this left four staff on C wing, no officers were present on the south spur of the wing for significant periods of time. The first and the third wing officers carried out cell inspections of the wing, starting with the north spur. The fourth wing officer left the south spur to take a television to be x-rayed and resealed. He was accompanied by a prisoner who needed to collect some clothing from reception. The fifth officer was supervising cleaning duties on the north spur and the wing SO was mobile between the spurs.

17. The exercise yard was open shortly after 9:00am. Prisoners were free to wander in or out as they pleased, which was the usual practice. The second wing officer recalled that, due to the cold weather, there were probably no more than four prisoners on the yard that morning.
18. The fifth wing officer said he did not remember anything untoward. He said the atmosphere on the wing seemed normal. Between 9:00am and 10:00am, he was supervising general cleaning duties on the north side. The wing SO said that he was organising a snooker competition within the wing, so was moving between the spurs. He remembered going to the north spur at about 9:45am. He pinned a notice about the competition on the notice board, and had a brief chat with some of the prisoners. He then went to the south spur, put up a notice and had a chat with about eight prisoners who were at the snooker table. Just before 10:00am, in his office on the ground floor, he began to supervise an inter-prison phone call between a prisoner and his brother in another prison. The first and the third wing officers carried out cell checks until about 10:00am. They returned to the wing office to complete the paperwork associated with the cell checks.
19. A prisoner on C wing, told my investigators that, at about 10:15 - 10:25am, he opened his cell door and saw “a crowd of people outside the door all just sort of looking in one direction towards the stairs.” He said he noticed the man lying under the stairs and thought he had been knocked out. The prisoner went back into his cell briefly and when he came out again, he noticed that the man appeared to be choking:

“... everyone was staring at him. No-one was going to go over to him, so I went over and approached him, put him into the recovery position because he was choking, tried speaking to him, waking him up, he was having none of it ... when I put him in the recovery position I realised the injuries to his head you could see all the bruising through his hair and he had like pretty thick hair, so then I knew that no prisoner could give him medical attention that he needed, so I went to the office [and] told the officers there was a lad that he was in a bad way.”
20. The prisoner said that another prisoner placed a [cardboard] box under the man’s head. Asked how long he thought the man had been lying by the stairs before he came out of his cell, the prisoner thought that it was roughly five minutes but no longer than ten. He said that his involvement ended after he told the officers about the man. He said he went to the gym, came back an hour later, went to the north spur of the wing, witnessed a disturbance and was sent back to the south spur.
21. The first wing officer told police that, between 10:05am and 10:10am, a prisoner approached him and the third wing officer whilst they were in the wing office and said there was a prisoner “in a bad way” on the ones landing. Both members of staff left the office and went onto the landing. The third wing officer saw the man lying unconscious under the stairs on the south landing ground floor. The man’s head was

resting on a cardboard box, he was bleeding from his nose and mouth, and had bumps and bruises all over his head. He described the man's breathing as noisy and rattling. He said he spoke to him, but there was no response. He did not touch him but called for immediate medical assistance over his radio whilst the first wing officer went to get the SO. The Risley Control Room Daily Log shows that the request for healthcare staff to go to C wing was made at 10:15am.

22. The first wing officer told my investigators that the man was "breathing very, very heavily, rasping breathing, and his hand was twitching so I knew he was alive, but it was obvious he wasn't very well, he was in a bad way." He went immediately to fetch the wing SO who arrived within a minute.
23. The wing SO said that, as he arrived, he radioed the communications room and asked how long it would be before healthcare staff arrived. He was told that the staff were on their way. The wing SO said that it was a couple of minutes before he realised that the prisoner on the floor was the man. There was a lot of blood coming from his nose but it appeared to be a different colour to that of a normal nose bleed. He recognised that the man had suffered a severe trauma to the head. The wing SO noticed that, despite his injuries, there was little blood around the man. He concluded that the man must have been assaulted elsewhere and dumped on the landing. He said that normally when there has been an incident, lots of prisoners gather around. On this occasion, although there were a few people milling around, a lot of prisoners were up on the upper levels looking down on to the ground floor. But it seemed quiet and subdued.
24. A Registered Mental Health Nurse (RMN) was on duty in the treatment room when he received the radio message to go to C wing immediately. He was not sure of the nature of the incident and, when he tried to telephone C wing, he was unable to get through. Accordingly, he took an emergency bag with him. His colleague a Registered General Nurse (RGN), followed him with oxygen. The RMN recalled that it was quite noisy, with prisoners milling around. On seeing the man, he told the wing SO that an emergency ambulance needed to be called immediately. An officer told him that the man had been assaulted. The RMN took the man's pulse which was strong and steady and noted that the man was breathing albeit with a snoring sound. He attributed this to a possible broken nose. He thought that the man might have suffered a spinal injury and, as he was already in the recovery position and the ambulance on its way, did not want to "interfere" with him. He noted that blood was oozing out of the man's sweatshirt and thought that the man had perhaps been stabbed, but he could not locate a puncture wound. On seeing the man, the RGN formed the opinion that he had suffered a head injury and that it might be life threatening.

25. The RGN said that the man did not react to being spoken to. Besides monitoring his pulse and blood pressure, there was little they could do until the paramedics arrived. Both nurses said that the ambulance took a considerable time to arrive. The RGN told my investigators:

“It was very frustrating. There were prisoners coming up and looking over and you know, they were told to move away and they would come back again, then they were up on the twos shouting ‘Where is the ambulance?’ ...we did ask on a couple of occasions where the ambulance was and I have learnt since that they had already said that they had put two out because they had got diverted because it was only put through as an amber call ...”

26. The RMN's and the RGN's perception of delay, commenting that the ambulance “seemed to take for ever”. The Risley Control Room Daily Log shows that an ambulance was requested at 10:20am. The call was logged by the ambulance control room at 10:23am. An ambulance was allocated at 10:34am. According to the clinical review, an ambulance “was then mobile at 10:39am”. At 10:40am, the prison telephoned the ambulance service to ask for the estimated time of arrival. They were told that two ambulances had been sent but had been diverted to other incidents. The call to attend to the man had now been made a priority and would not be diverted. An ambulance arrived at the prison at 10:50am. The RGN remained with the man until the paramedics reached him at 10:56am. The man was treated and stabilised by the paramedics and the ambulance eventually left Risley at 11:35am.

27. After the man had been discovered, the principal officer (PO) was asked to go to C wing in his role as the orderly officer in charge of incident response that day. He told my investigators that it took him three minutes to get to the wing. He described to my investigators what he saw when he arrived:

“He was lying there ... his body was shaking ... he had obviously ... been hit or something very, very badly on his temple ... the front of his face had been severely beaten, his nose and his mouth, he was struggling to breath. He was making a horrible noise trying to breath; I take it trying to breath through the blood inside his mouth, he was making this gurgling noise ... he was clearly in a lot of trouble.”

28. The PO established through one of the nurses already present that the man had a strong pulse and an ambulance had already been called. He asked the duty governor to make his way to C wing to see what had happened. He acknowledged to my investigators that this was an unusual request as incidents are normally managed at the scene, without the immediate intervention of the duty governor. The PO felt, however, that the assault on the man had been so serious that the duty governor needed to see what had happened.

29. In the meantime, the duty governor arrived and was concerned that many prisoners still had full sight of the man on the floor. He asked for a screen to be erected around the man to give him some privacy and to control access to the area. This was done. Having reiterated to the control room that the man was suffering from a serious head injury and an ambulance was needed immediately, the duty governor said he told the PO to “sort the ambulance out, sort the prisoners out and get your staffing and get back to as near a normal regime as possible.” He then went back to his office. At interview, he told my investigators that he had gone to C wing thinking that the incident had already been dealt with, and was unhappy on his arrival to see so many prisoners walking about whilst the man was still there.
30. The wing SO instructed staff to obtain some blankets, which were removed from the man’s cell, and a pillow. He asked his staff to check the wing for sites where the man might have been attacked. A cell was identified as seeming to have been freshly mopped. It was locked by an officer and its occupant was taken for a strip search.
31. Before and during the period when the man had been found, one prisoner had left C wing to attend the Roman Catholic Church service. From about 9:00am, outside exercise was taking place where prisoners were free to go on the yard if they wanted to. The second wing officer was supervising the exercise yard with the sixth. She thought that no more than four prisoners had been outside, although the sixth officer thought there might have been six or seven. Exercise continued until 10:40am when it was terminated to allow the ambulance access to the wing.
32. The Physical Education Instructor (PEI) arrived on C wing exercise yard at about 10:20am to escort a pre-selected class list to the gym. He recalled that about 25 prisoners were waiting for him, but he collected only the 16 prisoners whose names were on the class list. Six other prisoners from the class list, including the man, did not turn up and were marked as absent. The PEI began his class at about 10:25am and did not return them until about 11:40am.
33. At about 10:35am, the PO decided that there were too many prisoners in the vicinity where the man lay, and instructed staff to give prisoners a choice either to be locked in their cells or continue with association on the north spur if they wished. The fifth wing officer relayed this message to prisoners over the tannoy.
34. Some prisoners who remained on C wing were standing nearby watching staff attending to the man. More had congregated on the landings above where the man was lying and observed or shouted comments. The fourth wing officer said that he and other officers moved the prisoners away from the man towards the centre of the wing. He then stood at the top of the stairs from the ground floor to prevent prisoners going up and down. When the ground floor was

clear, he and others checked the cells on the other landings to make sure that the doors were locked. Then he checked the showers. He found a prisoner taking a shower in the communal showers on the first floor and told him he would have to go back to his cell.

35. The action of moving prisoners was welcomed by the nurses who were monitoring the man's condition. The RGN said that she found it off-putting being stared and shouted at by the prisoners. The RMN said that initially he was not bothered by the presence of other prisoners, as it was a usual occurrence when dealing with an incident. However, after a while he thought that the man needed more privacy and he didn't want "all this chaos around me ..."
36. The PO said that the prisoners were compliant with moving over to the north spur, so he did not think he needed additional staff to assist in clearing the south spur. The assistant orderly officer, was the only additional member of staff apart from the C wing officers assisting officers to clear the landings. Asked by my investigators whether she thought prisoners should have been locked up rather than given the opportunity to go to the north spur, she replied that it would have been very difficult trying to lock the prisoners located on the ground floor in their cells. With the man still there, this might have exacerbated the situation. She said it took about ten minutes to move all the prisoners from the south to the north. They were quiet and moved in an orderly fashion. She could not confirm that she had actually seen any staff on the north side, but thought that there would have been at least an officer on the ground floor and one on the top. At interview, the duty governor was asked whether it was conceivable that prisoners had been allowed to go to the north spur without supervision. He replied that this definitely would not have happened and guessed there would have been three or four officers present on the north spur.
37. Once all the prisoners had been ushered through to the north spur, the wing SO waited at the entrance to the wing to assist the paramedics in moving the man from the wing into the ambulance and out of the prison. The first wing officer remained with the man and the paramedics on the south spur. The third and fifth wing officers took the prisoner whose cell appeared to have been freshly mopped to be searched in an office on the first floor ("the twos") in the sterile area between the two spurs. The fourth wing officer remained on the first floor on the south side. The second wing officer and the sixth officer finished exercise early, so that the ambulance could get to the entrance of C wing. The sixth officer went to the first floor of the south spur to stop anyone using the stairwell and remained there. The second wing officer went to the north spur initially. She said that it seemed a normal atmosphere, with prisoners playing snooker, dominoes and asking her questions. After 10-15 minutes, she went into the staff room, which was through the gates, and into an office on the ground floor between the spurs to remove her coat. At that moment, there were no officers on the north spur.

38. The third and the fifth wing officers placed the clothing of the prisoner who was to be strip searched into sealed bags and gave him fresh prison clothing. They did not take his trainers, however, because they did not have any clean footwear to give him in return. The prisoner asserted that he had been on the north spur, prior to being searched and not done anything. (I understand he was later exonerated from any involvement in the man's death.) As they were finishing the search, the third wing officer heard loud banging coming from the landing on the north side of the first floor. This was followed by an alarm bell sounding at 10:56am.
39. The fifth wing officer requested assistance over his radio. The fourth wing officer went through the sterile area and joined the third and the fifth wing officers. According to the third wing officer in his police statement, there was a major disturbance involving around 100 prisoners who were shouting loudly and throwing items. He told my investigators that chairs, pool cues and wringers from metal mop buckets were being thrown. The officers decided to draw their wooden staves and opened the connecting doors to the landing. They raised their staves and gave the prisoners an order to back away. The prisoners responded instantly. The officers said that no prisoners were struck by them. It was immediately obvious that at least one prisoner involved in the melee had been injured and was bleeding profusely from a cut on his head. He was rescued by the officers. The wing SO arrived on the landing using the back staircase. He took the injured prisoner away and handed him over to another member of staff for treatment.
40. The second wing officer went back into the north spur when she heard the alarm bell. She said she saw the three officers enter the spur from the landing above. The prisoners who had congregated were moving away from them. The PO said that, when he heard the alarm, he entered the north spur from the ground floor and tried to get up the stairs. Prisoners were blocking his path so he had to push his way through. He described the scene he saw to my investigators:
- “... at the far end of the landing there was as I said it was absolute mayhem. There was people fighting and shouting, chairs and things being thrown. There were two prisoners who had been hurt. I didn't see the first one, he had already been dragged out by two other members of staff because I believe he was lying on the floor and he had been literally been dragged out through the door, to safety ... the second fellow ... had obviously been hit as well, he had, his shirt was torn to bits”.
41. The PO immediate thought was to withdraw from the spur because the prisoners far outnumbered the staff, but as he realised that “it was a prisoner on prisoner affair rather than prisoners against staff” he changed his mind. The PO asked for the rest of the prisoners to be

locked into the nearest cells, not necessarily their own, with the assistance of staff from the rest of the prison who had responded to the alarm bell. He said that the prisoners were not resisting staff and the situation was under control within a few minutes. Once the wing was quiet, prisoners were moved in small groups to their correct cells throughout the wing. Those who were on the south spur were returned there until staff were satisfied that all the prisoners could be accounted for. This took an estimated 15-20 minutes.

42. The PO then debriefed his staff, checked that they were alright and telephoned the duty governor to say that the wing had been locked up. According to the PO, the duty governor asked for the prisoners to be unlocked for association to continue. After some discussion, it was decided that the prisoners on C wing would remain locked up and lunch would be served in a controlled manner, only unlocking a few at a time. The duty governor told my investigators that his intention had been to get at least half of C wing up and running. At Rislely, the practice was to try to run a normal regime very quickly after a serious event. At interview, the PO described the C wing officers as being visibly shaken. Most of them had only been prison officers for a comparatively short time. He said that staff felt the mood of the wing (amongst prisoners) was that there was “unfinished business and that it was very, very volatile, it was bubbling.”
43. The PEI handed over the C wing prisoners to an officer at the gate to the wing at about 11:40am, after seeking permission from the control room to do so. He was asked to return to C wing afterwards to assist the serving of lunch. The PO estimated that there were ten more staff than usual to help patrol the landings, given the assault on the man and the subsequent disorder.
44. After the prisoners from the gym returned, the fourth wing officer and four prisoners went to the kitchen to collect lunch. Rather than everyone being unlocked as is usual, prisoners were allowed down to the servery a few at a time to collect their lunch and then returned to their cells. (There are two serveries on the wing, one for each spur.) At 12:06pm, a prisoner entered the servery on the south spur and struck one of the servery workers with an object in a sock. The assailant turned and ran, pursued by the wing officer. He was caught, restrained and taken to the segregation unit. Another prisoner ran after the assailant, but was headed off by an officer before he could reach him. That prisoner too was restrained by staff. Eventually, lunch was resumed and the prison roll was declared correct at 1:02pm.
45. The duty governor told my investigators that he decided to open the command suite after learning of the disorder on the north spur, which initial intelligence indicated had been sparked after the two prisoners suspected of attacking the man had been challenged. The command suite is an incident room located in the administration building, away from the prison residential units. The duty governor thought it had

been opened at about 11:30am, but written incident notes record the command suite as being opened at 12:50pm. The duty governor was joined by the other governor on duty that day, the PO, the assistant orderly officer, with an Operational Support Grade as the collator. The Prison Service's National Operations Unit was informed of the situation at 12:50, as were the Area Manager and the governing Governor shortly afterwards.

46. The duty governor said that he had a check list of who needed to be contacted and worked his way down the list. He thought he had asked a member of staff earlier to contact the police, but could not remember whom he gave the instruction to. It was only when the governing Governor arrived at the prison, and asked whether the police had been contacted, that Risley realised they had not been.
47. According to Cheshire Police, the initial telephone call from the prison was timed at 2.05pm that day. An operator took the call and, after some initial confusion over the correct address of the prison, the incident was graded as a grade two response. This meant that the call was to be treated as prompt and an officer should attend within one hour. This was based on the force's policy and the following facts - The man was already in hospital, it was a serious assault but not in progress, no uniformed response required due to the circumstances and location and there was a specific request from the caller that no-one attend at the prison.
48. The recording of Risley's initial 999 call to the police at 2:05pm said in part

“... although the Governor doesn't want anyone to come in at the moment, he'd like to speak to somebody if that's possible.” My investigators discussed with the police's Senior Investigating Officer, the Detective Inspector, the implications of the delay between the time the man was discovered and the time the police eventually arrived (at 3:25pm). It was his opinion that this delayed the securing of the crime scene by appropriately trained officers.
49. When the police arrived where the man had been discovered, they found it secured and taped off wall to wall across the bottom of the stairs including the cells on either side of the landing. Various police teams then arrived during the afternoon and a number of prisoners were arrested and taken to different police stations. Subsequent contacts between Risley and the police were facilitated by the Police Liaison Officer. I understand that the arrangement worked very well. The Governor held a hot debrief for staff at 8:15pm that evening. He updated staff on the man's prognosis and thanked staff for their efforts.
50. After leaving Risley by ambulance, the man arrived at the local hospital at 11:48am. After a CT scan, he was found to have severe brain damage. The assistant orderly officer attempted to contact members

of the man's family by telephone but was unable to reach anyone in person. A member of Risley's chaplaincy team was asked to continue the task and contacted the man's brother at 1:40pm to alert him to the seriousness of the man's condition. The man was given the last rites and transferred that afternoon to the specialist hospital where he underwent surgery. He remained unconscious and critically ill and his prognosis was described by the hospital as very poor.

51. On 14 November, the man was released from custody on temporary licence due to his condition. This meant he was no longer accompanied by prison officers at his bedside, although he was visited by a duty governor and the chaplain. Risley also maintained contact with the hospital by telephone approximately every four hours to ascertain the man's condition. On 17 November, when Risley rang the hospital at 10:10pm, they were told that the man had passed away at 7:45pm that evening. His family were present when he died.
52. A governor was appointed as Risley's family liaison officer (FLO) for the man's family on 18 November. He contacted the man's aunt by telephone to offer members of the man's family the opportunity to visit Risley if they wished. The Director General of the Prison Service wrote to the man's aunt on 18 November to express his sympathy.
53. One of the investigators and my family liaison officer visited the man's aunt to learn of issues that she wished to raise. The aunt said she wanted to know the reason for the man being attacked and why he had been found under a stairwell when she had heard that previously he had apparently been seen walking into another prisoner's cell. She said that she should have first been contacted by the prison FLO after the man had been attacked, not after he had died. The family had lost confidence in the Prison Service after receiving the Director General's letter which made reference to the police saying "the police were immediately called into the prison following the assault ...". However, the police had made it clear to her that they had not been contacted by Risley until some four hours after the assault on the man had been discovered. As a consequence, she felt that she had been misinformed and did not wish to have further contact with the Prison Service as she could not rely on the information she had been given as correct, although she did welcome contact with a priest from the chaplaincy team.
54. Risley let staff and prisoners know about the man's death through informative notices which gave as much detail as they were able. A book of condolence was opened on C wing for prisoners to write their own tributes. In addition, a collection initiated by prisoners raised £340.00. They were sent to the man's family who were touched by the generosity as well as the many sympathy cards they received. A floral wreath was placed outside the man's cell. A minute's silence was held at the prison in memory of the man and an inter-wing five-a-side

football match was organised but, due to the overwhelming number of entries, was eventually cancelled as it was felt to be impractical.

55. During interviews with my investigators, several staff indicated that the constant presence of drugs, gangs and mobile telephones had proved a challenging combination to manage at Risley. This is borne out by the recent report by Her Majesty's Inspectorate of Prisons to which I referred earlier and which explores the inter-relationship between security issues and violence in the establishment in more detail.
56. The wing SO was asked by my investigators about issues on C wing and relationships between different groups of prisoners. He said that C wing had been tackling various issues like the use of drugs, assaults and instability caused by prisoners arriving from other areas. But up until the assault on the man it had been going through a fairly good period.
57. The governor in charge of C wing was asked about the staff-prisoner relationship before the man's death. He said there had been a period of instability a couple of years prior, marked by changes in wing managers, but that things had turned around. He said the staff on C wing had worked really hard and established a great deal of stability. They had built up a team ethic and were engaging with prisoners to establish good relationships. He felt that the staff had raised the wing to a good standard and he was devastated by what happened to the man. The governor acknowledged that prison can be a violent place but said he had never come across this level of violence. He expressed sympathy for the man's family.
58. He acknowledged that Risley had a constant issue with countering prisoner gangs connected to drugs. He said that, although there was some intelligence that the man had used drugs, he was not involved in anything more complex. My investigators checked the wing observation book and security information but were unable to find evidence to indicate that Risley could have foreseen the serious assault on the man.
59. A post mortem was conducted on 18 November, the day after the man's death. It gave his cause of death as "blunt force trauma to the head." A clinical review into the care the man received at Risley was conducted by the Assistant Director of Health Standards at Warrington Primary Care Trust. In her report, she says that in an emergency situation it would be expected that the nurses would have attended to the man's airway, breathing and circulation:

"Airway – The nurses should have made sure that the man's airway was clear, this did not appear to happen – the nurses did not examine his airway, they assumed that he was breathing noisily because his nose was broken.

“Breathing – The nurses should have ensured the man’s breathing was optimised – the nurses did this by monitoring the man’s respiration rate, but failed to attempt to address an abnormal rate by increasing the patient’s uptake of oxygen. The nurses could have completed a physical examination of the man to identify if there was a neck injury. It may have been possible to lift the patients head slightly to facilitate putting on the oxygen mask or, if not, a nurse could have held the mask in place to increase uptake of oxygen.

“Circulation – the nurses appeared to have addressed the man’s immediate needs in this respect as they monitored his pulse. However, the nurses already identified that he had lost blood, appeared to have bruising and appeared to be in pain. It would be reasonable to assume that he would be shocked. When qualified health professionals attend to a patient in an emergency situation it would have been reasonable to expect that they use equipment and drugs available in the emergency bag to establish IV access and start an infusion if they were trained to do so. The two nurses in attendance did not identify this need and were not trained to perform those skills. Members of the public may have difficulty understanding why nurses had access to equipment that could potentially save life that they were not trained to use. Although the nurses were not trained to establish IV access, they could have given oxygen and monitored the man’s level of consciousness more closely. An accurate assessment of consciousness levels would have assisted secondary care in his treatment.”

60. The RMN told the reviewer he had not dealt before with the type of assault the man had suffered and felt out of his depth. He did ask for an ambulance to be called and gave basic first aid. He took the man’s pulse, but did not examine him for fear of disrupting an injury.

61. The clinical review concludes that, on balance, the care given to the man was not as good as it could have been. However, “the review was unable to establish whether or not the omissions of staff influenced the outcome for the man. If he had received IV fluids and oxygen it may have improved his prognosis.”

62. The clinical review queries why the officers who were first on the scene did not call an ambulance straightaway rather than waiting for the arrival of the nurses. My investigators asked Risley for their policy in this regard. They were sent a memorandum from an Operational Support Grade which read in part:

“ ... I have looked everywhere and can’t find any instructions or contingencies. I can confirm, however, that it is only control staff that ring 999 for ambulances and that is only usually done at Healthcare’s request i.e. in the event of a medical emergency, H1 would be summoned to the scene and would then request emergency services via control.”

63. The clinical review also expresses concern about the delay in the arrival of the ambulance. The delay of over 30 minutes is outside the expected national standard of eight minutes.
64. The review concludes that, “the issues raised in this review give cause for concern both in terms of individual staff actions, team supervision and the strategic and operational management of the service. Therefore there are some recommendations to be made to the PCT Board and the Prison Health Partnership Board in responding to this report.”
65. It makes a number of recommendations that are listed at the end of this report.
66. In line with the Prisons and Probation Ombudsman’s Office’s practice of providing advance disclosure of draft reports to the Prison Service where identifiable members of staff are criticised, the RMN and the RGN were given sight of the report. Risley’s healthcare manager asked for the following points to be considered:
67. “Immediately upon arrival at the scene, the nurses requested that an Emergency Response Vehicle be called. The man had already been placed in the recovery position and due to the perceived nature of the injuries, the nurses felt that it was not appropriate to move him. He was observed to be breathing adequately, therefore an airway was not inserted, there were also concerns over causing further trauma to his apparent facial injuries. The man’s circulation/cardiac output was monitored via his pulse rate and peripheral circulation. Both nurses were aware that an ambulance had been called and anticipated that the paramedics would arrive imminently. The injuries that the man sustained presented the nurses with an extremely critical situation. This fell beyond the scope of their normal practice and duties, however they are satisfied that the basic principles of life support were observed.”

ISSUES

68. The man suffered serious injuries that led to his death four days later. That these injuries should have occurred in prison makes them all the more disturbing – perhaps all the more so given that they appear to have taken place out of the blue in a relatively low security prison. However, I have not found any evidence to suggest that Risley knew an attack on the man was likely or imminent.
69. I have been careful to leave the question of what exactly occurred to the police. I asked my investigators to focus on whether Risley's response to what happened was timely and appropriate.
70. The man was left lying on a landing. I have not been able to establish with any certainty how long he was there before he was found, but there are indications that he could have been there for some time. It is clear that the actions of another prisoner who put the man in the recovery position (having learnt first aid whilst in prison) were invaluable.
71. Of the seven staff on duty on C wing that morning, three were allocated to each spur with the senior officer mobile between the two spurs. Most of the staff were carrying out tasks that took them away from observing the landings and the prisoners for some time. This is partly a matter of wing design, with offices located away from cell areas, and meant that whatever took place could do so without staff seeing or hearing anything untoward. This cannot have been lost on any prisoners involved.
72. Even within a relatively low security establishment, there should not have been periods when either spur was left unobserved by staff. All the more so, given that 30 per cent of prisoners told HM Inspectorate of Prisons that they felt unsafe at some point whilst in Risley, and assaults and bullying are a concern in the prison in general. Although Risley has been rebuilt to include modern facilities, CCTV has not been installed.

The Governor should review the deployment of staff with the aim of enhancing the level of surveillance, enabling prisoners to be confident that their safety is a priority.

The Governor should consider the feasibility of providing means of electronic surveillance.

73. When the third wing officer approached the man whilst he was lying injured, he immediately called on his radio for healthcare staff to attend. After they arrived five minutes later, an ambulance was requested. The officer's actions were prompt and there can be no criticism attached to him. He acted in accordance with the existing practice at Risley. There is no policy or instruction for staff being able

to telephone for an ambulance. A memorandum provided to my investigators on the subject said, "it is only control staff that ring 999 for ambulances ..."

74. Prison Service policy, issued via a letter to governing Governors in March 2004, on the access of ambulance and paramedic services states:

"It is essential in clinical crises that prisoners should have rapid access to emergency paramedical services ... The critical factor in survival rates is the time it takes a trained paramedic to reach the patient (access for a vehicle is of secondary importance).

"It is the responsibility of the Governing Governor to ensure that a protocol exists at each prison to facilitate the immediate access to both the prison and the individual prisoner when emergency paramedic services are summoned. It is also essential that internal procedures should not waste undue time in summoning emergency assistance. It should not, for example, be a requirement in every case for a member of the Healthcare Team to attend the scene before Emergency Services are called. However, a subsequent 999 call to the Ambulance Service should be made to cancel the response if, after the original 999 call has been made, a member of the Healthcare Team arrive with the patient and deem that an emergency ambulance response is not required."

75. It was obvious to staff from the time they saw the man that he had been seriously injured. If the officer knew he could have requested an ambulance immediately, it might have avoided the significant delay in the arrival of an ambulance which then followed.

The Prison Service and Department of Health should re-issue the guidance to all Governors on the calling of an emergency ambulance and ensure that staff at all levels are aware of its contents.

76. I can only imagine the anxiety of both staff and prisoners as they waited for an ambulance to arrive. Thirty minutes is a very long time to have to wait, given that the NHS standard deems eight minutes as reasonable. It is important to say, however, that the ambulance service has its own system for allocating ambulances and the Prison Service cannot tell it what level of priority should be given.

The PCT should request that the Ambulance Service conduct a serious event analysis of the allocation of the emergency service vehicle for the man who died.

77. Creating a regime which allows prisoners as much free time out of their cells as possible at the weekends is laudable. At Risley, prisoners were unlocked from breakfast until lunchtime to do as they wished

within the wing. The duty governor spoke at interview about wanting to get back to a normal routine as soon as possible. Ordinarily, I would agree. However, from the descriptions staff have given of the man's condition there could have been no doubt that his condition was life-threatening. It was likely that a serious criminal offence had been committed by persons who were on the wing. The man's medical needs were addressed in terms of getting nurses to the scene, calling an ambulance and making him as comfortable as possible. However, the need to isolate the scene and preserve evidence by limiting movement was pursued with less vigour or co-ordination.

78. After the man was found, prisoners were allowed to attend church, go on to the exercise yard, leave the wing for the gym, even have a shower – movements which provided opportunities for evidence to be lost. Prisoners were able to approach the area for some twenty minutes while the man was being attended to on the ground floor landing. When they were guided away by officers, prisoners were still able to overlook the scene by standing on the upper landings. I am not convinced that this translated into sufficient regard for the management of the unfolding events or recognition of its importance.
79. Prisoners were given a choice to be locked in their cells, which only a minority exercised, or continue association on the north spur. It was known that there were only six staff on the wing, two of whom were still outside supervising exercise. When exercise was brought to an end, this still left insufficient staff to monitor twice the number of prisoners normally present on a spur, especially when there was likely to be a heightened state of agitation after what had happened to the man. There was no realisation by the manager that a significant number of prisoners were being allowed to go to the north spur with only one member of staff present, on the ground floor. Even if a disturbance had not occurred, this situation would have been undesirable. And when the member of staff left, albeit briefly, the prisoners were left to themselves.
80. This is not just an issue about the numbers of staff vis-à-vis the number of prisoners. Given that many prisoners may have known what exactly had happened to the man, it was an incendiary situation waiting to ignite. The three officers who successfully intervened when unrest broke out showed bravery in confronting a dangerous situation to rescue a prisoner and bringing the incident under control. Their actions are to be commended. It is thanks to their courage that more prisoners were not seriously injured or worse.
81. The assault in the servery afterwards, even during a controlled unlock, showed that increased numbers of staff were not a sufficient deterrent to any prisoner determined to attack another. However, the speed with which the unrest was contained is an example of how potentially dangerous situations may be minimised and controlled.

82. The duty governor opened the Command Suite after deciding that the man's injuries and the subsequent disorder constituted a serious situation. Prison Service Order 1400 – the Incident Management Manual deals with the strategy for the control of serious incidents. In the section on post incident procedures it says:

“During and after a serious incident it is likely that crimes will have been committed. If a prosecution is to be successful, the rules governed by the PACE Act 1984 must be followed. Police advice ... will be critical in this respect ... From the start of an incident, the Police will wish to gather as much evidence as possible to assist in criminal prosecutions.”

The Governor should review the existing arrangements for dealing with serious incidents and consider whether the establishment could benefit from consultation with the local police concerning scene preservation and exhibit handling.

83. It is very regrettable that Risley did not inform the police until almost four hours after the man was discovered. There was some confusion as to who was supposed to contact them and what time the request had been made. The duty governor was certain that he asked for the police to be contacted, but could not recall who the request was directed towards. In any event, it was not followed up and it was only on the Governor's arrival in the afternoon that it was realised that the police had not been called. Earlier involvement by the police would have been beneficial in directing the efforts made to manage the crime scene, and collect and preserve evidence. However, I am heartened to learn that, despite the initial delay, subsequent communication between Risley and the police was excellent.
84. Unfortunately, Risley's contact with the man's family was less successful. While the family were told of the man's injuries, it was only after the man's death they were assigned a family liaison officer who then contacted the man's aunt. This was interpreted as a lack of concern for the family, given that Risley had been responsible for the man's well-being.
85. It is also unfortunate that the letter sent by the Director General to the man's aunt the day after the man died said that the police were called immediately. I do not know who prepared the letter, or what the Director General meant by “immediately”, but the family's unhappiness demonstrates the importance of providing information that is as unambiguous as possible. Because of what was perceived as misinformation, the man's family decided not to have further contact with the Prison Service, although Risley's Roman Catholic chaplain has been of comfort to them.
86. The Governor may wish to satisfy himself that accurate information was passed to the Director General's office. The Director General may

wish to satisfy himself that he was fully appraised when he signed off the letter to the man's aunt.

87. Although family liaison officers are normally appointed following the death of a prisoner, it would be good practice to consider whether one is needed in cases where serious or life-threatening injuries have occurred.

The Governor should devise a local contingency plan to cover liaison with families in the event of serious and/or life-threatening injury to prisoners.

88. The clinical review makes three recommendations that I endorse:

The Primary Care Trust, in agreement with the prison, should determine the role of the healthcare team in responding to healthcare emergencies on prison wings.

The Primary Care Trust should review the skill mix of staff in the healthcare team so that the team can effectively deal with healthcare emergencies.

The Primary Care Trust should ensure that incident reporting processes at Risley are effective.

89. It was good practice to release the man on temporary licence, and remove the bedside prison officer escort, the day after the man was taken to hospital when it was considered he was unlikely to survive.
90. A number of actions were taken by Risley and C wing prisoners to mark the man's death which his family found touching and showed a proper respect for him as a person.

RECOMMENDATIONS

National

The Prison Service and Department of Health should re-issue the guidance to all Governors on the calling of an emergency ambulance and ensure that staff at all levels are aware of its contents.

Local

The Governor should review the deployment of staff with the aim of enhancing the level of surveillance, enabling prisoners to be confident that their safety is a priority.

The Governor should consider the feasibility of installing means of electronic surveillance.

The Governor should review the existing arrangements for dealing with serious incidents and consider whether the establishment could benefit from consultation with local police concerning scene preservation and exhibit handling.

The Governor should devise a local contingency plan to cover liaison with families in the event of a serious and/or life-threatening injury to prisoners.

Primary Care Trust

The Primary Care Trust should request that the ambulance service conduct a serious event analysis of the allocation of the emergency service vehicle for the man who died.

The Primary Care Trust, in agreement with the prison, should determine the role of the healthcare team in responding to healthcare emergencies on prison wings.

The Primary Care Trust should review the skill mix of staff in the healthcare team so that the team can effectively deal with healthcare emergencies.

The Primary Care Trust should ensure that incident reporting processes at Risley are effective.