Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of a man, a prisoner at HMP Doncaster in February 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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

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

In February 2015, another prisoner at HMP Doncaster punched the man and he lost consciousness. He was taken to hospital, but died from a fractured skull and brain injury. He was 43 years old. I offer my condolences to his family and friends.

The man's assailant pleaded guilty to manslaughter and received a further prison sentence. This investigation has examined whether there was anything the prison could have done to prevent his death. I consider it would have been difficult for the prison to have identified that he was at particular risk from his attacker. However, I am concerned that there was little indication of a structured and coordinated approach to challenging violent behaviour at the prison and appropriate protection of potential victims. Prison staff responded quickly to the emergency, but did not call an ambulance immediately. While it does not appear that this affected the outcome for him, in future emergencies, such a delay could be critical.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **November 2015**

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Summary

Events

1. The man had been released from a prison sentence for manslaughter in 2011. He was recalled to prison in 2013, and then released from a further sentence in June 2014. In August 2014, he was recalled to prison again and sent to HMP Doncaster. He had previously been convicted of a sexual offence but was not regarded as at risk because of this and therefore not located on a vulnerable prisoner wing.

2. On 4 December 2014, a prisoner was remanded to Doncaster. He had been there before and had a history of involvement in drugs and fights in the prison. The prisoner and the man lived on the same wing, but there is nothing to indicate that they had much contact. The prisoner said he knew of the man, as he was a wing cleaner and notably tall.

3. On 21 January, the man found a significant amount of drugs on the wing, which he handed to staff.

4. On 11 February 2015, the prisoner was unwell. Nurses examined him and suspected he had been smoking 'Spice', a new psychoactive substance. He was not referred to the substance misuse team and no one completed a security information report.

5. Towards the end of February, the man was standing on the landing talking to another prisoner. The prisoner walked by and punched him on the head. He fell to the ground and the prisoner walked away. Officers responded quickly. They found him unconscious and bleeding from his head but did not use an emergency medical code for four minutes. Only then, did the control room call an ambulance.

6. The man was taken to hospital and discovered to have a bleed on the brain and a fractured skull. At 9.10pm, doctors pronounced him dead. The prisoner was subsequently convicted of manslaughter.

Findings

7. The man had previously been convicted of sex offences, which carry a stigma among other prisoners. He had also recently handed to staff a significant find of drugs. There were anecdotal accounts that the prisoner had said he was going to attack him because he was a sex offender. While we do not know what provoked the prisoner's attack, and he has given no credible reason, the investigation found that the prison did not consider whether the man should have been protected as vulnerable to attack. We are also concerned that the prisoner's anti-social behaviour was not effectively challenged.

8. Staff did not use an emergency code when they found the man unconscious, which resulted in a delay calling an ambulance. Although this did not affect the outcome for him, in other cases such a delay could be crucial. We are also

concerned that the staff did not do enough to preserve evidence at the scene, which could have compromised the police investigation.

9. The prison did not inform the man's family that he was in a critical condition and had been taken to hospital, so they were unable to visit him before he died.

Recommendations

- The Director should ensure that there is a coordinated approach to identifying indicators and risks of bullying and violent behaviour, including the impact of new psychoactive substances, and that suspected perpetrators are monitored and challenged through effective interventions as part of a robust violent reduction strategy.

- The Director should ensure that reception and first night staff consider and discuss with newly arrived prisoners with a history of sexual offences, whether they should be separated as vulnerable prisoners and that all prisoners who might be at risk from other prisoners are monitored and appropriately supported.

- The Director should ensure that all staff are aware of their responsibilities in a medical emergency and use an appropriate emergency code, which ensures an ambulance is called immediately.

- The Director should ensure that, when a prisoner has been seriously assaulted, the police are notified without delay, all relevant evidence is preserved and that prisoners who could be under suspicion of the assault are identified quickly and held separately until the police arrive.

- The Director should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without unnecessary delay.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Doncaster informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

11. The investigator visited Doncaster on 5 March. She obtained copies of relevant extracts from the man's and the prisoner's prison and medical records.

12. NHS England commissioned a review of the man's clinical care at the prison and the prisoner's mental health, which was carried out by a clinical reviewer. The investigator and clinical reviewer interviewed nine members of staff and the investigator interviewed a prisoner at Doncaster. They also interviewed the prisoner at HMP Leeds.

13. We informed HM Coroner for Doncaster of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. West Yorkshire police shared all witness statements and evidence from their investigation.

15. One of the Ombudsman's family liaison officers wrote to the man's partner to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond.

Background Information

HMP Doncaster

16. HMP Doncaster is a local prison, operated by Serco, which holds up to 1,145 remanded and sentenced men over 18. There are three houseblocks with four wings, each holding between 90 and 96 prisoners. Nottingham Healthcare provides physical and mental health services, and substance misuse services

Her Majesty's Inspectorate of Prisons

17. The most recent inspection of HMP Doncaster was in March and April 2014. Inspectors reported a serious problem with illegal drugs in the prison. Prisoners told them that the use of new psychoactive substances, such as Spice, was common.

18. Inspectors reported that staff appeared overwhelmed by the challenges facing them on wings and lacked control of busy houseblocks. There had been serious violent acts that staff had been unable to control, especially when there were only two officers on duty. Inspectors considered that managers did not show visible leadership and support.

19. A significant amount of security information was analysed well. Required actions were carried out quickly.

20. Prisoners reported concerns about their safety. The level of assaults was four time higher than at similar prisons. Inspectors found systems for managing violence and bullying were weak. Other than downgrading bullies to the basic regime, little was done to challenge and alter their behaviour. There was little support for victims beyond locating them on the vulnerable prisoner wing.

21. Doncaster had responded promptly to PPO recommendations after previous deaths at the prison, but inspectors were not confident that the changes would be long-term.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to September 2014, the IMB reported an increase in the use of spice, which had led to a rise in incidents of violence. They noted that the prison had distributed leaflets highlighting its danger to prisoners.

Previous deaths at HMP Doncaster

23. The man's death was the first homicide we have investigated at Doncaster. In another recent investigation into a death at the prison, we were concerned about the availability of new psychoactive substances.

Assessment, Care in Custody and Teamwork (ACCT)

24. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

KEY EVENTS

25. In 2006, the man was convicted of manslaughter and received an indeterminate prison sentence with a minimum period to serve of 17 months before he could be considered for release. He was released in April 2011. On 30 December 2013, his licence was revoked for possessing weapons (three knives). He received an eight-month prison sentence and was sent to Doncaster on 8 January 2014. An entry in his record of 9 January, noted that he might be vulnerable to assault because there were previous sexual offences recorded on the police national computer. (He had been convicted of rape and other sexual offences in 1992.) However, he did not go to the vulnerable prisoner unit. On 4 February, he moved from Doncaster to HMP Hatfield and was released on 23 June 2014.

26. In August 2014, the man was recalled to prison again after being arrested for carrying a blade in a public place. He arrived at Doncaster on 12 August 2014. His escort record noted that he was regarded as a risk to female staff.

27. An initial custody assessment noted that the man had previously used heroin and was withdrawing from alcohol. Reception staff began Prison Service suicide and self-harm prevention procedures known as ACCT. A reception officer recorded on his cell sharing risk assessment that he must not share a cell with ethnic minority prisoners, as he was racist. The officer noted a history of violence and self-harm, and that he was a threat to female staff. (Staff closed the ACCT on 4 October 2014.)

28. During the man's induction, staff gave him information about safer custody and violence reduction, the system for reporting bullying and the services of Samaritans and peer supporters. During his reception and induction period, no one considered whether he should be allocated to the prison's vulnerable prisoner wing because of his history of sexual offences and he did not request this.

29. Officers gave the man a random mandatory drug test on 5 September. The results were negative, showing no traces of drugs.

30. On 8 November, staff opened an ACCT when the man received a letter from his partner ending their relationship. Staff discovered that the letter was not genuine and another prisoner had written it. At a case review the next day, staff closed the ACCT. He said that he was not concerned about the hoax letter and no one investigated this further.

31. On 12 December, staff began ACCT monitoring again because the man said his indeterminate sentence was causing stress in his relationship with his partner.

32. On 21 January, the man was helping an officer stock a storeroom on the houseblock. While unpacking milk cartons, he discovered that one of the cartons contained 25 'wraps' of Spice and reported this to the officer. The officer submitted an intelligence report and the security department asked officers to be vigilant. No one suspected that he was using or involved in using or supplying the drugs he had found. During a meeting the next morning, the deputy director

asked a unit manager whether his safety would be compromised. He was assured that it would not be.

33. On 29 January, at an ACCT case review meeting, the man said he had been upset because he had thought he was going to be transferred to another prison, and he wanted to stay at Doncaster until his parole hearing in March. He settled and, on 6 February, asked for his ACCT to be closed. The supervising officer closed it, with the agreement of those at the case review.

The Prisoner

34. On 4 December 2014, the prisoner was remanded to Doncaster charged with burglary, possessing drugs and carrying a knife. He had a history of cocaine, methadone and heroin use. At an initial health screen, he told a nurse he suffered from anxiety and depression and was prescribed mirtazapine. He tested positive for cocaine, opiates, amphetamines and benzodiazepines and the nurse referred him to a GP and the prison's substance misuse clinic. He began a methadone (heroin substitute) maintenance programme.

35. Later on 4 December, officers found a large paper wrap containing a green leafy substance (likely to have been a new psychoactive substance) and reported this to the security department. Officers did not charge the prisoner with a disciplinary offence, although they noted the incident on his record. Healthcare staff monitored his withdrawal symptoms over the next few days and had no concerns.

36. On 9 December, the prisoner was released on bail, but was remanded again on 16 December for theft. At his initial health screen, he reported that he had used drugs again in the community and he began another methadone programme. His cell sharing risk assessment indicated that he could share a cell, but he was a high risk to other prisoners because of his racist and homophobic views.

37. The prisoner had a fight with another prisoner on 18 January. Both men were charged with a disciplinary offence and he was put on the basic level of the incentives and earned privileges scheme. This meant he lost some privileges, such as time out of cell and a television. On 25 January, he returned to the standard regime level.

38. On 19 January 2015, the substance misuse team reviewed the prisoner and decided that he was stable on 30mg of methadone a day. They planned to begin a reduction programme if he was convicted.

39. On 28 January, the prisoner was sentenced to 16 weeks for burglary, having a knife in a public place and possessing a Class A drug. Later that day, an officer found on another landing of the wing, where he was not authorised to be. He said he was passing a message to another prisoner. The officer gave him a formal behaviour warning. Two days later, an officer found him on another landing where he should not have been. The officer told him this was not allowed, but took no further action.

40. On 5 February, the prisoner punched another prisoner in the face several times and officer put him on the basic regime level again. He told officers that other prisoners were threatening him because he was in debt. An officer noted that he was both a victim and a bully, but did not begin any formal violence reduction measures as this information was not current.

41. On 11 February, staff saw the prisoner smoking in the exercise yard. A short time afterwards he appeared lethargic and then started to vomit. Officers took him back to his cell and asked a nurse to examine him. The nurse suspected he had taken Spice (another name for NPS). He was already on basic level of the IEP scheme and no other action was taken. The security department were not notified and he was not referred to the substance misuse team.

42. On 23 February, an officer searched the prisoner as part of a routine security check. He found a pipe, an unauthorised item associated with drug use, and charged him with a disciplinary offence. The officer informed the security department, but not the substance misuse team.

The day of the incident

43. Officers unlocked prisoners for breakfast at 8.00am, as usual. Throughout the morning, prisoners went to activities. From 12.30pm, they began to collect their lunch.

44. The prisoner told the investigator that he had a disagreement the man at lunchtime that day, but he could not remember what it was about. No other prisoners or officers remembered this. There is no specific record about what the man or the prisoner did that afternoon, but, unless they were working, most prisoners were locked in their cells. The man was a wing cleaner and would usually have been cleaning on the wing from 1.15pm onwards. The prisoner would have been locked in his cell. At 5.10pm, officer unlocked cells to allow prisoners to collect their evening meal.

45. About 5.30pm, the man asked an officer if he could speak to a Supervising Officer (SO). He did not say what this was about. The SO was busy elsewhere at the time and unable to speak to him.

46. At 5.57pm, CCTV shows the man standing with another prisoner on an upper landing, chatting, and looking over the landing rail. He was noticeable because of his height. (He was six foot eight inches tall.) At 5.58pm, the prisoner went up the stairs and began to walk along the landing towards him. As the prisoner walked past, he punched the man once in the head. The man collapsed to the floor and the prisoner quickly walked to the other end of the landing.

47. At 5.58pm, an officer said he heard a dull thud and saw a prisoner lying on the floor. He was at the man's side within 20 seconds and radioed for medical help. He checked his airway. The man was breathing and his nose was bleeding; he was also bleeding from his head. The officer could not get a response from him. He did not radio a medical emergency code to alert staff to a life–threatening

incident and to prompt the control room to call an ambulance. Another officer arrived seven seconds later, closely followed by a colleague.

48. A nurse heard the radio call for medical help. She was close by and had an emergency bag with her, so went straight to the landing. (The bag contained equipment for responding to emergencies involving blood injuries.) She radioed to say she would attend and would let other healthcare staff know if she needed further assistance. She reached the man at 6.02pm and found him lying on the floor, in the recovery position.

49. Several prisoners had crowded around and the nurse asked officers to move them away. Officers began locking prisoners in their cells, including the prisoner who had punched the man. One prisoner said to an officer, "He didn't deserve that". He told the officer that a prisoner had hit the man because somebody had told him the man was a sex offender. The officer passed this information to a manager and to a SO.

50. The nurse checked the man's airway and could see he was breathing, but could tell his condition was critical. She asked a SO to request an ambulance and he radioed a code blue medical emergency at 6.02pm. The control room then called an ambulance immediately.

51. At 6.04pm, the nurse went to collect the nurses' emergency bag containing oxygen (used for code blue emergencies) from the nurses' room. The officers stayed with the man. They did not move him.

52. Another nurse and a healthcare assistant responded to the code blue call and arrived at 6.05pm. The first nurse returned with the emergency bag at 6.06pm. The second nurse checked the man's blood pressure and used an oximeter to check his oxygen level. The healthcare assistant mopped the blood from his head with a swab. She said she could hear him gurgling and rattling, as if he were trying to breathe. A nurse began to clear away the blood that had spilt on the floor, as it was spreading around the man and the nurses, and he considered it a hazard.

53. A manager arrived and helped nurses roll the man on his side so they could see where the blood was coming from. The manager said that the man said he had been punched, then became unresponsive. (The manager was the only person to recall the man regaining consciousness.) A nurse checked his pupils. The left side of his face was so swollen she could only check his right pupil, which was fixed and dilated. The nurses continued to help him breathe, supported his head and kept talking to him, but he did not respond.

54. Paramedics arrived on the landing at 6.11pm and a nurse explained what had happened. They assessed the man and considered he had suffered a serious brain injury. At 6.38 pm, the paramedics took him to hospital. The manager and an officer went with him. They did not use restraints.

55. At about 6.40pm, a manager and a SO went to the prisoner's cell and found him sitting on the bed. His cellmate was talking on the integral telephone in the cell.

The SO told him that they were taking him to the segregation unit. On the way, he asked him what he had done. He said that had hit another prisoner because, "He's a dirty wrong un". He was held in the segregation unit and officers started ACCT monitoring because they considered that he was at risk of suicide and self-harm.

56. The man arrived at hospital at 6.51pm and hospital staff took him to the intensive care unit. At 7.15pm, he had a CT scan. A doctor at the hospital told the manager that he had a bleed on his brain and a fractured skull. He was being artificially ventilated to help him breathe, but was neurologically unresponsive.

57. The doctor spoke to neurosurgeons at another hospital and agreed that there was nothing they could do to save the man. At 9.10pm, doctors pronounced him dead.

58. The prison called the police at about 9.20pm, and the police arrived at the prison at 9.48pm.

Information from prisoners

59. After the man's death, a number of prisoners told the police that the prisoner frequently hit prisoners to pay off a debt, or others would pay him to do it as a debt enforcer. One prisoner submitted an anonymous note alleging that the prisoner had been paid to hit the man. Another prisoner said that he had overheard the prisoner telling other prisoners that he had been paid to assault a prison officer, but that as the officer was not on duty at the time he had decided to hit the man instead.

60. A prisoner said that he had overheard the prisoner telling another prisoner that he was going to "smash the man's face in" because he was a sex offender. The prisoner said he did not know who he was talking about at the time. Other prisoners said that they had heard him talking about the man being a sex offender. Prisoners told the Assistant Director that a number of prisoners on the wing thought the man was a sex offender.

Contact with the man's next of kin

61. There is no evidence that anyone at the prison considered contacting the man's partner when he was taken to hospital in a critical condition, or before he had died. After he had died, the police said they would break the news to his family, due to the circumstances of his death. At 11.14pm, they were still trying to contact them. The police informed the man's father and his ex-partner that night, who were also recorded as his next of kin.

62. The prison and the police continued to try to contact the man's partner. Eventually, at 1.24pm on 3 March, the police managed to speak to her by telephone. She explained that she had been uncontactable as she had been in hospital. On 6 March, the prison's family liaison officer and a prison chaplain visited her and offered condolences and support. The prison contributed to the costs of the funeral, in line with national Prison Service policy.

Support for prisoners and staff

63. On Saturday 28 February, the Director held a debrief for the staff involved in the emergency response to give them the opportunity to discuss any issues arising, and to offer support. Unfortunately, some officers who did not usually work on A Wing were overlooked. The staff care team offered support to those who attended the debrief.

64. The prison posted notices informing other prisoners of the man's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by his death.

Post-mortem report

65. A post-mortem examination concluded that the man suffered a fractured skull and brain injury, caused by the blow to his head and the fall to the floor.

Interview with the prisoner

66. On 30 April 2015, the prisoner pleaded guilty to manslaughter and on 26 May was sentenced to four years imprisonment. As he had pleaded guilty, his motive for punching the man was never subject to cross-examination in court. He told police that he had attacked him for no reason.

67. After his conviction, the investigator interviewed the prisoner at HMP Leeds. He said that he and the man had had an argument at lunchtime on 27 February, although he could not remember what it was about. He said he had 'stewed' on it during the afternoon and that is why he had punched him that afternoon. He said that he had never really noticed him before, although he knew he was a wing cleaner.

68. The prisoner denied being paid to hit the man and said he was not in debt to anyone. He said he had not taken drugs or any other substance apart from his prescribed methadone.

69. The prisoner said he was taking medication for his mental health at Leeds and suffered from anxiety and depression.

FINDINGS

Managing the prisoner's risk

70. While we recognise that there was little to indicate that the prisoner was a specific risk to the man, we are concerned that he had a propensity to violence that was not effectively managed and monitored. It is possible that some of this was related to drug use and involvement and trading in drugs, including new psychoactive substances. Other prisoners said that he was paid by drug dealers to assault prisoners to enforce debts or to pay off his own debts. He was found a number of times on landings where he should not have been.

71. The day he arrived at Doncaster, in December 2014, officers found what was described as a 'green leafy substance', evidently a new psychoactive substance in his cell. On 11 February, the prisoner vomited and appeared to be under the influence of a new psychoactive substance but no action was taken. On 23 February, he was found with a pipe associated with drug use.

72. New psychoactive substances are an increasing problem in prisons nationally. As well as emerging evidence of dangers to both physical and mental health, trading in these substances can lead to debt, violence and intimidation. We do not know whether the prisoner's actions were as a result of involvement in drugs, but we note that both HM Inspectorate of Prisons and the Independent Monitoring Board identified their use as an increasing problem at Doncaster. We also found this during the investigation into another death at Doncaster, two months before the man died. We made a recommendation about the need for strategic approach to dealing with the problem, linked to the prison's drug supply reduction and violence reduction strategies.

73. The clinical reviewer examined the prisoner's medical notes but concluded that there was no evidence that he had significant mental health issues at the time of the man's death. He was satisfied that there was nothing from a healthcare perspective that could have indicated the prisoner was a risk to others, or that he was likely to assault the man.

74. At the last inspection, HM Inspectorate of Prisons was very concerned about the level of violence at Doncaster and found that systems to manage violence reduction were weak with little evidence of a strategic approach. There were no interventions to challenge anti-social and violent behaviour and to support victims.

75. The prisoner had been identified as a high risk of violence to some other prisoners because of his racist and homophobic views. On 20 January 2015, officers found him fighting with another prisoner and placed him on the basic regime level, although only for five days. On 5 February, he punched another prisoner in the face. He was again placed on the basic regime but no other action was taken. We are concerned that despite these known incidents, no formal action was taken under the prison's violence reduction scheme to challenge his behaviour. We make the following recommendation:

The Director should ensure that there is a coordinated approach to identifying indicators and risks of bullying and violent behaviour, including the impact of new psychoactive substances, and that suspected perpetrators are monitored and challenged through effective interventions as part of a robust violent reduction strategy.

The man's safety

76. There was no intelligence to link the prisoner with the man before his death. There was no information that the man was at risk from the prisoner or any other prisoner until after his death. The only indication that he might have been a victim of some form of bullying in the prison was when he received a hoax letter in November 2014, purporting to be from his partner, ending their relationship. We do not know the motivation for this; he said he was not concerned about it and staff did not investigate it further.

77. On 21 January 2015, the man discovered a quantity of drugs (new psychoactive substances) hidden in a milk carton and alerted officers. It is possible that this could have made him vulnerable to attack from other prisoners on the wing, who had smuggled the drugs into the prison. There is no record that staff identified this possibility or took any steps to monitor his safety after he handed over the drugs.

78. There is no record that the man requested to be located in the vulnerable prisoners unit at any time, or that anyone asked him, despite his history of sexual offending. It is possible that he chose not to be managed as a vulnerable prisoner. However, as other prisoners later suggested that the prisoner assaulted him because he was a sex offender, we are concerned that there is no evidence that anyone discussed the risk with him.

79. As the prisoner has given no credible account of his motivation for assaulting the man, and there was no evidence linking the two men, we recognise that it would have been difficult for the prison to have identified that he was specifically at risk from the prisoner or prevent his attack. However, we consider that the prison gave insufficient consideration to his general vulnerability. We make the following recommendation:

The Director should ensure that reception and first night staff consider and discuss with newly arrived prisoners with a history of sexual offences, whether they should be separated as vulnerable prisoners and that all prisoners who might be at risk from other prisoners are monitored and appropriately supported.

Emergency response

80. PSI 03/2013 *Medical Emergency Response Codes,* issued in February 2013, contains a mandatory instruction that prisons should have a local protocol which gives guidance on efficiently communicating the nature of an emergency and that there are no delays in calling an ambulance. It explicitly states that all prison

staff must be made aware of and understand the protocol and their responsibilities during emergencies.

81. Doncaster has local procedures, which are in accordance with the protocol, but officers did not follow them when they found the man unresponsive. An officer did not radio an emergency code red or blue, so the control room did not call an ambulance immediately.

82. Because of the injuries incurred, it is unlikely that the failure to follow emergency procedures would have changed the outcome for the man. However, even a short delay in an emergency can have a significant impact on a person's chance of survival and it is important that managers ensure that all relevant prison staff understand and follow emergency procedures. We make the following recommendation:

The Director should ensure that all staff are aware of their responsibilities in a medical emergency and use an appropriate emergency code, which ensures an ambulance is called immediately.

Preserving evidence

83. After the man collapsed, the prisoner was locked in his cell for about 40 minutes before he was relocated to the segregation unit. In this time, vital evidence could have been lost. A nurse began to clear up the man's blood, as he believed it was a safety hazard. He was not aware of the prison's protocol for preserving evidence, which had not been shared with all healthcare staff.

84. The prison did not contact the police until after the man had died. The paramedics told the prison that his condition was critical when he left the prison. The police should have been informed as soon as it came to light that he had been seriously assaulted by another prisoner.

85. PSI 09/2014 (Incident Management) notes that prisons should have contingency plans to ensure incidents are resolved with the minimum of harm to staff, prisoners and the public. The principles that underpin this include preserving evidence. We make the following recommendation:

The Director should ensure that, when a prisoner has been seriously assaulted, the police are notified without delay, all relevant evidence is preserved and that prisoners who could be under suspicion of the assault are identified quickly and held separately until the police arrive.

Informing the man's next of kin

86. The man was taken to hospital in a critical condition at 6.38pm. Doctors pronounced him dead at the hospital at 9.10pm. No one from the prison had contacted his family before he died. Prison Rule 22 requires that when a prisoner becomes seriously ill, the Governor should "***at once*** inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed".

87. When the man was taken to hospital, his condition was critical and we consider the prison should have informed his family straight away. Any delay in informing families when a prisoner is seriously ill or has suffered sudden life-threatening harm can mean that families miss the opportunity to see them before they die. We make the following recommendation:

The Director should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without unnecessary delay.

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Independent Investigations

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