Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of a man, a prisoner at HMP Rochester, in October 2014

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.

The man died in October 2014, from respiratory complications from a head injury, while a prisoner at HMP Rochester. He was 28 years old. I offer my condolences to his family and friends.

On 12 October 2014, another prisoner punched the man, who fell and hit his head on the floor, causing the injuries from which he died. The other prisoner 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 the man was at particular risk from his attacker. However, I am concerned that there was little evidence of a structured and coordinated approach to challenging violent behaviour at the prison, which appears to have been destabilised by the problems associated with the widespread use of new psychoactive substances.

I am satisfied that the man received appropriate treatment after he was attacked and there was no immediate indication that an ambulance was needed. However, once the seriousness of situation was identified, it took too long to notify the police. I am also concerned that it took the prison three days to contact his family after he was taken to hospital.

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 **May 2016**

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Summary

Events

1. On 28 March 2012, the man was sentenced to two years in prison for burglary. He was released on licence and recalled to prison a number of times during this sentence. On 1 October 2013, he was sentenced to four years in prison for a further offence of burglary. He had drug problems, suffered from depression, and had a history of self-harm and attempted suicide.

2. In January 2014, the man was moved from HMP Wormwood Scrubs to HMP The Mount. While he was at The Mount, he had a poor disciplinary record. Staff found a number of illicit items in his cell, including new psychoactive substances (NPS) and mobile telephones. He was involved in some assaults. On 23 July, he moved to HMP Rochester. He settled well but began missing work and said he was being bullied. He began to take antidepressants again. In August, staff found a mobile telephone charger in his cell. He said another prisoner had threatened him to make him hold it for him. He was moved to another wing.

3. On 6 September, the man self-harmed while serving a punishment of cellular confinement in the segregation unit for refusing to attend work and was moved to a safer cell on A Wing. Staff began ACCT procedures. He said he was being bullied and named the alleged perpetrators, but there is no record of an investigation. On 12 September, he went back to C Wing. The next day, staff ended suicide and self-harm monitoring.

4. On 20 September, the man's cellmate alleged that the man had threatened him at knifepoint. His cellmate was moved to another wing and left the prison a week later. There is no evidence of any investigation. On 24 September, staff found NPS, a mobile telephone charger and superglue in his cell. He was placed on a basic regime and lost privileges.

5. At around 10.00am on Monday 12 October, a prisoner was assaulted by other prisoners. (At the time, he told staff he had hurt his arm accidentally.) At 11.20am, four prisoners, including the man, tried to assault him in his cell. He managed to push them out and, by the time an officer arrived, they had dispersed. A few minutes later, some prisoners tried to assault him again. He and some other prisoners were locked back in their cells. Prison staff did not know whether the man was involved in this incident, although another prisoner said he was.

6. At 11.33am, the man was in a cell with two other prisoners when one of them pushed him out. Prisoner A was standing outside the cell and punched him, who fell to the floor. Staff arrived quickly and assessed him. Seven minutes later, they called an ambulance. He was conscious but could not stand up. He was taken to hospital and diagnosed with bleeding on the brain and a cracked skull. Doctors placed him in an induced coma. The prison did not manage to contact his partner until three days later. A few days later he died in the hospital after he contracted a chest infection and had a cardiac arrest. The prisoner subsequently pleaded guilty to manslaughter.

Findings

7. Staff and prisoners said that the man was in debt to other prisoners due to his use of new psychoactive substances and was vulnerable to threats as a result. He told staff he was being bullied, but we found that this and other allegations of threats and violence at the prison were not effectively investigated. We are concerned that the easy availability of NPS at the prison had led to increased levels of violence and there was no effective strategy to deal with this.

8. Although we are concerned about the general levels of violence at Rochester, connected with NPS, there was no specific intelligence to indicate that Prisoner A was a threat to the man and we do not consider that staff could have anticipated that the man was at risk from him and have prevented the attack. The prisoner said that he was in fear for his own safety and had punched him impulsively, but it appears he might have been retaliating for the earlier attack on another prisoner.

9. Staff reacted calmly and competently when the man was assaulted. However, we are concerned that they did not follow the correct procedures for a medical emergency, a weakness we have found before at Rochester. We are also concerned that the prison took over four hours to inform the police that he had been assaulted and that there was a delay of over three days before they informed his next of kin and other family that he had been admitted to hospital.

Recommendations

- The Governor 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 associated debt. All allegations of violence, bullying, or intimidation should be taken seriously and investigated appropriately. Suspected perpetrators should be monitored and challenged through effective interventions and potential victims supported as part of a robust violent reduction strategy.
- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013, the local protocol, and their responsibilities during medical emergencies and that:
    - Staff efficiently communicate the nature of a medical emergency using the appropriate code;
    - The control room calls an ambulance as soon as an emergency medical code is received, or an ambulance is requested.
- The Governor should ensure that when a prisoner is seriously assaulted, the police are notified without delay, in line with PSI 47/2011.
- The Governor 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 Rochester informing them of the investigation and asking anyone with relevant information to contact them. No one responded.

11. The investigator visited Rochester on 28 October 2014. She obtained copies of relevant extracts from the man's prison and medical records. In line with the Ombudsman's terms of reference, the investigation was suspended while Kent Police conducted a criminal investigation. The police shared all witness statements and evidence from their investigation.

12. The investigator and a colleague interviewed 13 members of staff at Rochester in September and October 2015. Additionally they interviewed a member of prison staff at our office, a prisoner by telephone and the prisoner who was found guilty of the man's manslaughter. The investigator did not receive a reply from an ex-prisoner at Rochester, who she had written to for information.

13. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

14. We informed HM Coroner for Mid Kent and Medway of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted the man's sister, his partner and his partner's mother, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Both she and the investigator subsequently met his sister. His sister had a number of concerns as follows:

    - Whether officers had dealt with the fight before he was assaulted appropriately.
    - Why it had taken the prison so long to contact her after he had been taken to hospital
    - The security arrangements when he was in hospital.
    - That his cell had been tidied up when his family visited, contrary to their wishes.
    - His family had had to chase the prison to pay for the funeral.

16. The man's partner and her mother wanted the investigation to consider the following:

    - They claimed that an officer had changed his sedation levels at the hospital and wanted to know whether this was usual.
    - They were concerned that it had taken the prison four days to tell his partner that he was in hospital.
    - The reasons why he had been moved to Rochester when he had had good support at his previous prison.

17. The man's sister and partner received copies of the initial report. The solicitor representing the man's sister wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor. The man's partner pointed out a factual inaccuracy. This report has been amended accordingly. His partner also raised an issue that does not impact on the factual accuracy of this report and has been addressed through separate correspondence.

18. The National Offender Management Service (NOMS) also received a copy of the report. They accepted all the recommendations. They highlighted one factual inaccuracy relating to a recommendation that healthcare staff bring equipment to an emergency. We have removed the recommendation from this report.

Background Information

HMP and YOI Rochester

1. HMP and YOI Rochester is a medium security prison holding about 650 men over 18. Oxleas NHS Foundation Trust delivers primary physical and mental health services in the prison.

HM Inspectorate of Prisons

2. The most recent inspection of Rochester was in September 2015. Inspectors found that levels of violence were high and many prisoners felt unsafe. The management of the perpetrators of violence was inadequate, although there was good support for victims. There was a major problem with the use of new psychoactive substances (NPS - such as “Mamba” or “Spice”, both synthetic cannabinoids). Intelligence was analysed quickly and the security department was well informed about current issues about drugs, NPS, mobile telephones and maintaining order and control. Some intelligence-led searching was not done quickly enough.

3. Inspectors found that around 40 prisoners had isolated themselves in their cells because they were afraid about threats they had received for debt related to their use of NPS. Some had been identified as at risk of suicide and self-harm as a result. The prison was planning a 'community development unit' for such prisoners and to offer them enhanced peer-led support.

4. Inspectors found a number of staff were not aware of the prison’s emergency response protocol including the medical emergency code system.

Independent Monitoring Board

5. 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 June 2015, the IMB was very concerned about the availability of drugs in the prison and the associated health problems, debt, violence and self-harm. Despite some significant finds by staff, the dealers had not been deterred. Staff shortages had meant a restricted regime and cutbacks to rehabilitative courses. Prisoners spent more time on the wings and in their cells, and the prison was unable to offer purposeful activity to all prisoners. The IMB considered that this had affected staff and prisoner morale.

Previous deaths at HMP Rochester

6. There have been four deaths at Rochester since the Prisons and Probation Ombudsman began investigating deaths in prisons in April 2004. In October 2014, a prisoner died from a drug overdose and our investigation identified concerns about drug use and intelligence gathering. In an investigation into a self-inflicted death in May 2015, we found that staff at Rochester needed to investigate bullying more thoroughly. In both these investigations, we also made recommendations about the use of emergency codes.

Assessment, Care in Custody and Teamwork

7. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. Once a prisoner has been identified as at risk, the purpose of the ACCT process is to try to determine the level of risk, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held.

8. PSI 64/2011 sets out how staff might manage prisoners whose behaviour is so challenging and disruptive that they need additional case management to manage the risk of harm to self, to others and/or from others. A prison manager oversees the enhanced ACCT case management process and ensures a higher level of coordination between the different teams involved in the prisoner's care.

New Psychoactive Substances

9. New psychoactive substances (NPS) are an increasing problem across the prison estate. They are difficult to detect, as they are not identified in current drug screening tests. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting.

10. As well as emerging evidence of dangers to both physical and mental health, it is possible that there are links to suicide or self-harm. Trading in these substances, while in prison can lead to debt, violence and intimidation.

11. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with use of NPS. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies because of the links between NPS and debt and bullying.

Incentives and Earned Privileges (IEP) Scheme:

12. Each prison has an Incentives and Earned Privileges (IEP) scheme, which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are four levels, entry, basic, standard and enhanced.

Key Events

13. On 28 March 2012, the man was sentenced to two years in prison for burglary. He was released from this sentence, but recalled to prison three times during 2013. On 3 September 2013, he was recalled to HMP Wormwood Scrubs and, on 1 October, was sentenced to four years for a further offence of burglary.

14. The man used heroin and cocaine and had a history of self-harm and attempted suicide. He was prescribed methadone to treat opiate dependency and sertraline (an antidepressant). Staff monitored him under Prison Service ACCT suicide and self-harm prevention procedures until 31 October.

15. The man found it difficult to cope with the length of his sentence and had problems associated with the deaths of his parents when he was younger and witnessing a friend being killed by a train. He was supported by a substance misuse worker and a mental health nurse.

16. On 17 January 2014, the man moved to HMP The Mount. While he was there, he was involved in an assault, found with illegal items (including NPS and mobile phones) and failed mandatory drug tests. He was often on the basic level of the Incentives and Earned Privileges scheme because of his behaviour and spent time in the segregation unit for short periods of punishment. He self-harmed and attempted suicide at The Mount and was managed under ACCT procedures.

17. On 23 July, the man moved to HMP Rochester while still assessed as a risk of suicide and self-harm. The reason for the move was not recorded. Initially he appeared to settle well and staff ended ACCT procedures on 28 July.

18. On 5 August, a mental health nurse assessed the man and noted he had moderate to high depression and anxiety. On 8 August, a doctor prescribed sertraline, which he had not taken for a few months.

19. On 8 August, officers found a mobile phone charger in the man's cell. He said another prisoner, who he would not name, had threatened him and made him keep it for him. Staff moved him from A Wing to C Wing but there is no record of any investigation into his claim that he had been threatened. An officer became his personal officer on C Wing. He did not know exactly why the man had been moved but believed he had been bullied to hold things for other prisoners.

20. Officers told our investigators that the man was quiet and did not speak to staff about his difficulties. They said he seemed vulnerable, appeared younger than he was and was easily influenced. Staff and prisoners we spoke to said he was in debt for drugs (mainly NPS) and other prisoners paid him to hold items, such as drugs or mobile telephones. He also delivered drugs for other prisoners or would clean prisoners' cells to help repay his debts. Staff submitted a number of security reports about his activities and involvement with drugs.

21. On 4 September, the man missed his fifth work session of six in three days and was charged with a disciplinary offence. On 6 September, he was given a punishment of seven days cellular confinement in the segregation unit and cut his arms. Staff began ACCT procedures and he said he would not cope with segregation. He said that someone he worked with was threatening him. A

mental health nurse assessed him as suitable to be segregated but he tied a ligature around his neck when he was moved to the segregation unit.

22. A custodial manager held a case review and decided to move the man to a safer cell on A Wing. (Safer cells have fewer ligature points.) There were no mental health staff present at the review. Staff identified that bullying was an issue and a Supervising Officer (SO) noted that he had identified the prisoners who were bullying him. However, there is no record of an investigation. Staff noted that the mental health team should assess him and he should find a prison job away from the prisoners who were bullying him. The custodial manager scheduled a case review for the next day so that a member of the mental health team could be present.

23. A custodial manager and supervising officer held further case reviews on 7 and 8 September, but no mental health staff attended. On 12 September, the man went back to C Wing. A custodial manager acting alone, ended ACCT monitoring, although no one from the mental health team had assessed him and he had not found another job as planned.

24. On 20 September, the man's cellmate alleged that the man had forced him at knifepoint to masturbate in front of him. Staff moved his cellmate to another wing, and then to a different prison. Although his cellmate said he wanted the police involved, there is no evidence the matter was investigated further. Staff noted that the man should be subject to violence reduction monitoring and reviewed on 29 September.

25. From 22 September onwards, the man did not have a prison job. The records show he had been employed in two different workshops before this, but had not attended satisfactorily, due to sickness or problems with other prisoners.

26. On 24 September, staff found superglue, NPS and a mobile phone charger in the man's cell. He was demoted to the basic level regime for a week. On 29 September, a SO noted that staff had not filled in his violence reduction document and closed it.

27. The personal officer said that the man became more withdrawn around the beginning of October. He offered him an unpaid job as a wing cleaner to get him out of his cell more. The officer said he seemed pleased about this and began to interact more with other prisoners.

28. On 10 October, a nurse noted that the man had rarely collected his antidepressants since 18 September and informed the Head of Healthcare and Head of Safer Custody. She telephoned C Wing to ask him to collect his medication and booked a GP appointment for 15 October.

29. For security reasons all prisoners' phone calls, apart from legally privileged calls, are recorded. Staff listen to a random sample, unless there are particular security concerns. Prison staff were not monitoring the man's calls and had not listened to them. The investigator listened to his calls. He telephoned his partner four times on the afternoon of 10 October. He asked her to send him credit for a mobile telephone to pay for his tobacco. He indicated that he sometimes had access to mobile phones in the prison.

30. At 9.30am on 11 October, the personal officer spoke to the man about not taking his medication and encouraged him to collect it. He said he had not collected it because he felt depressed. The officer telephoned an officer in the safer custody team and she advised that they should consider opening an ACCT. She telephoned the mental health team to refer him urgently and spoke to a SO on C Wing. The SO agreed to speak to him.

31. Later that day, the man collected and took his antidepressant. He said that he wanted to see a doctor to review his medication and the nurse told him an appointment had been arranged for 15 October. The SO later emailed the officer to say that she had spoken to him, he had collected his medication that morning, and she had no immediate concerns about him. There is no evidence that the mental health team assessed him.

32. The man telephoned his partner three times that afternoon. She was not in so he spoke to her mother. He said he had not been taking his medication but that officers were "looking out" for him. The conversation finished when his credit ran out.

12 October

33. Around 10.00am on 12 October, during an association period (when prisoners are able to mix with each other on the wing) a prisoner on C Wing asked Officer A if he could go to the healthcare centre as he had cut his arm on a cupboard. He was treated in the healthcare centre and came back to the wing. (Months later, during the investigation into the man's death, he told police that in fact he had been assaulted).

34. At 11.20am, Officer A was in the wing office when he noticed that the prisoner's cell bell was repeatedly being pressed and then reset (switched off) by someone. From the CCTV monitor he could see a group of prisoners on the landing outside the cell. He went to the cell and heard the prisoner shouting to other prisoners walking away, "It took four of you!" so he suspected there had been a fight. The prisoner was inside the cell and looked flustered but uninjured. The officer noticed drops of blood on the landing but the prisoner said it was not his.

35. The investigator watched the CCTV footage and noted that a group of prisoners, including the man, had tried to force their way into the prisoner's cell. The prisoner pushed them back out. The man kicked his door and mopped up some blood outside the cell. (It is not clear whose blood this was.)

36. Officer A went back to the wing office to review the CCTV. At the time, the live CCTV showed prisoners shutting the doors at the end of the landing near the prisoner's cell. The officer had just opened these doors, which were usually kept open. He immediately went back to the landing and found a group of around 15 prisoners chasing the prisoner. They were holding sticks and crutches as weapons. Another officer pressed the general alarm to summon help from all available staff. This disturbance took place out of sight of CCTV cameras and we have therefore not been able to determine exactly who was involved.

37. More staff arrived and they separated the prisoners. Officer A moved the prisoner away. He estimated it took around five minutes to deal with the incident.

He said that he had intended to lock the man in his cell for his own safety immediately but had not done so and could not remember why. He went to speak to some of the prisoners who had been involved in the incident. He said three had been locked in their cells, as they had been aggressive to staff who were trying to disperse them. He then locked the prisoner in his cell and decided to move him to the segregation unit for his own protection. He thought this would be preferable to moving a large group of prisoners before they had established exactly what had happened.

38. In a statement to the police, the prisoner said that earlier that morning he had been involved in a dispute with a prisoner in one of the cells next to him, who kept banging on the cell wall. He said this prisoner and some of his friends had tried to attack him and he had been hit on the back of the head with a weapon made out of something heavy inside a sock. He had walked away but noticed his arm was bleeding and then went to the healthcare centre to have it treated.

39. The prisoner said that when he got back four prisoners had tried to assault him in his cell but he had pushed them out. Shortly afterwards, when he left his cell, a group of prisoners tried to attack him again. A prison officer locked him back in his cell and he was taken to the segregation unit for his own protection.

40. Officer A did not specifically notice the man during either of the attacks on the prisoner. He went back to the wing office to look at the CCTV to try to establish a sequence of events and who had been involved. While he was doing this, at 11.33am, two prisoners went into Prisoner 1's cell. The man walked down the landing behind them and CCTV shows that he seemed to be talking to Prisoner 1, who was outside his cell. Prisoner 1 told the investigator that he did not remember talking to him. He said he had been standing outside his cell when the other two prisoners went in. He said he was surprised at this and did not know why they had gone into his cell. One prisoner told the police he had gone to Prisoner 1's cell to get some tuna and the other prisoner had gone to get a computer game.

41. One prisoner beckoned the man into the cell but five seconds later, he pushed him back out. He told the police that this was because the man would not give him the tobacco he owed him. Prisoner A was standing outside the cell and when the other prisoner pushed the man backwards out of the cell, he punched him on his jaw and he immediately fell backwards to the floor. The man appeared not to have seen him. Prisoner 1, who was still standing outside the cell, said he believed the man was knocked unconscious.

42. We interviewed Prisoner A at HMP Elmley on 23 September 2015. He said that he had been on C Wing at Rochester from around January 2014 and that he knew the man but they had never talked to each other or had any disagreements. He believed the man was in debt to other prisoners for NPS, and that they sometimes threatened and assaulted him to recover the debt.

43. Prisoner A said he was a distant relation of the prisoner who was assaulted and they had met for the first time on C Wing at Rochester. He said this prisoner looked out for him, as he was worried about being assaulted. On 12 October, he said he saw the prisoner when he was on his way to get the cut on his arm treated. He said that the next time he saw him, a group of prisoners were

chasing him and he had a cut lip. The only prisoner he recognised among the group was the man.

44. Prisoner A had heard from other prisoners that the prisoner in the cell next to his distant relation had assaulted him that morning because of an argument about debt for NPS. Later that morning, he said he suspected that someone had been in his cell while he had been out. He said that when he saw the man and another prisoner go into someone else's cell he went to see what was happening and to ask if they had been in his cell. He said he saw the man punch someone inside the cell and then back out of the cell with his fists clenched. He said he thought he might be going to hit him also, so he punched him on the jaw.

45. Prisoner A said he had no issues with the man, and his distant relative had told him and other prisoners earlier not to get involved in his disagreement. He said that he had been upset that his relative had been assaulted, but denied that he had punched the man in response.

46. The prisoner who was assaulted told the police that when Prisoner A was taken to the segregation unit after the assault, he had shouted that he had done it in retaliation for the earlier assault on him. He said he had nothing to do with the assault on the man and he had not asked anyone to retaliate on his behalf. He said he had got on well with the man.

47. A prisoner went to get help from two officers, who were on another landing. They went straight to Prisoner 1's cell and found the man lying on the floor outside. There were no other prisoners near him at the time. Officer B went back to the entrance to the landing to press the general alarm. CCTV showed this was 11.34am. Officer C stayed with the man, who was trying to get up. He was very disoriented and there was blood on the back of his head. The officer tried to put him in the recovery position. Officer C told the investigator that he thought he had radioed for staff assistance and had asked Officer B to request healthcare staff to attend. Officer B said that healthcare staff usually respond to a general alarm, but staff also call them separately if needed. She could not remember telephoning healthcare staff but said she might have done.

48. A nurse told the investigator that she was in the healthcare centre when she got a phone call asking her to C Wing. She and a colleague went immediately and took an emergency bag with them. When they arrived, the man was conscious and asked her to help him. He had a large swelling on his jaw and on the back of his head. He said he was dizzy and had a headache. He was in a crawling position on the floor and was unable to sit up when she asked him. He seemed confused and restless. She tried to apply an ice pack to his jaw and the back of his head but he took it off. She was unable to check his pupils, as he could not raise his head. He vomited some saliva, which contained blood. She said she asked an officer to call an ambulance.

49. At 11.40am, control room staff checked whether an ambulance was needed. A custodial manager who had arrived at the scene confirmed this. The control room then called one. A nurse checked the man's blood pressure and oxygen saturation levels, which were normal. The ambulance arrived at the prison at 11.52am (according to ambulance service records) and the paramedics were with him two minutes later. After they assessed him, they requested an air

ambulance. Two officers and the paramedics walked him to the ambulance they had arrived in. When he was in the ambulance, an officer used an escort chain to restrain him. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to the officer.)

50. Paramedics tried to assess the man further in the ambulance but he was resistant to treatment. The air ambulance arrived at 12.35pm. The air ambulance doctor assessed him and agreed he should go to the local hospital in the standard ambulance. The officers went with him.

51. At 3.24pm, a custodial manager telephoned Kent Police to tell them about the incident. Later that afternoon, the Head of Safer Custody telephoned the man's partner, who he had named as next of kin, using the number in the prison record. He got no answer and left a voicemail message asking her to contact the prison.

52. Hospital staff diagnosed that the man had a fractured skull and intercranial bleeding and doctors placed him in an induced coma. The Head of Safer Custody then agreed that officers could remove the escort chain.

13 – 19 October

53. On 13 October, Officer A telephoned the man's partner using several different telephone numbers he had found in the man's records, but got no response from any of the numbers. He telephoned the man's probation officer, who did not have any telephone numbers on file. The officer noted that he would try the youth offending team the next day. He asked someone to get the telephone numbers the man had last called, from the prison telephone system. However, when he discovered that the man had received no reply from the numbers he had dialled in the previous week, he did not try them, as he assumed they were no longer in use.

54. When doctors tried to bring the man out of his induced coma, he became aggressive and violent, and tried to pull the tubes from his body and get up. Doctors therefore sedated him again. Managers increased the number of escort officers to three, in case help was needed to control him when he was brought out of sedation again.

55. On 14 October, a doctor tried to bring the man out of the coma again, to assess his injuries but he was resistant and had to be sedated again. An officer came back to work that day, after two days off, and noted that the man's family still did not know he was in hospital. She tried to call his partner on two other telephone numbers, which were in his records, but got no answer.

56. At a prison disciplinary hearing on 14 October, Prisoner A said that he had overheard the man telling another prisoner outside Prisoner 1's cell that he had assaulted a prisoner, as the prisoner had assaulted him before. He said he did not believe that this prisoner would have assaulted the man and immediately punched him. He later told an officer that he would not have punched him if he had not assaulted the prisoner.

57. On 15 October, an officer looked for alternative numbers to contact the man's family and found that he had called his partner's mother on 11 October. She called this number and on the second attempt spoke to her. His partner was not

available so the officer told her mother that the man was in hospital and asked her daughter to telephone the prison for more details.

58. An hour later, the man's partner called the officer, who explained that another prisoner had assaulted him and he was in hospital. She partner asked why she had not been told sooner and said she would let his sister know. The officer apologised for the delay in getting in contact. Later that day, the Head of Safer Custody asked the officer to act as the prison's family liaison officer.

59. At 5.20pm, the man's partner, sister, and other family members, arrived at the hospital. The family liaison officer and an officer met them there. Hospital staff told them that the man was in a stable condition at the time. On 16 October, he suffered complications on condition, including a chest infection. He remained in an induced coma. The family liaison officer went to the hospital to support the family.

60. A few days later, the man's condition deteriorated and, at 12.15pm, the escorting officers left his bedside. At 1.00pm, doctors told his family that his condition was critical. He had a cardiac arrest and died at 4.12pm that afternoon. His family were with him at the time. The family liaison officer telephoned the man's sister, who was the main family contact, to pass on her condolences and offer support.

61. The prison arranged for the man's partner and sister to collect his belongings from the prison and see his cell. The family liaison officer said the cell had been left exactly as it was when the man was last there. Officer A said the bed cover might have been pulled across the bed but nothing else would have been moved. A coroner's lock had been on the door so only the police had been allowed in.

62. In line with Prison Service instructions, the prison contributed to the costs of the man's funeral. (His sister said this was not paid until the day before the funeral, which had caused them some worry. The family liaison officer was not aware that she had been worried about this at the time, so was unable to reassure her.)

Support for prisoners and staff

63. There was no formal debrief for staff after the man died. All of the staff we spoke to said they had felt adequately supported, apart from an officer, who said that no one had spoken to him to offer support. He had been with the man at the hospital for a number of days and had been distressed by his death. (The investigator drew the officer's concerns to the attention of the prison's Head of Human Resources.)

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. A prison manager told Prisoner A that he had died. The prison held a memorial service for all staff and prisoners in the prison chapel.

Post-mortem report

65. The post-mortem examination concluded that the cause of death was respiratory complications following a head injury. The toxicology report analysed the man's

hair, which indicated that he had used NPS for more than six months before he died.

Prisoner A's trial

66. On 17 August 2015, Prisoner A pleaded guilty to manslaughter and on 19 August was sentenced to four years in prison. As he had pleaded guilty, his motive for assaulting the man was never subject to cross-examination.

Findings

The man's safety

67. The investigation identified a number of general concerns about the operation of violence reduction procedures at Rochester and the availability of new psychoactive substances (NPS), which we deal with below. It is evident from our interviews with prisoners and staff that, at the time of the man's death, the prevalence of NPS at Rochester had led to significant control problems and a lack of safety at the prison. Against that backdrop, the likelihood of a serious assault, which sadly, in this case led to a death, might have been predicted. However, while the Prison Service must take some responsibility for the general lack of safety at Rochester, we do not consider that staff at Rochester could have predicted that Prisoner A would have assaulted him on 12 October 2014, or that there was any specific reason to keep them apart.

68. There was no intelligence to link the man and Prisoner A before the man's death. Staff said Prisoner A's actions were completely out of character and he was not usually aggressive. On the day of the assault, Prisoner A had not been involved in the earlier disturbances on the wing. He was a distant relative of the prisoner who was assaulted, but officers were not aware of this and did not believe them to be particularly close.

69. Officers did not think that there were any problems between the man and the prisoner who was assaulted. This prisoner told the police that until 12 October he had got on well with him and had taken him under his wing to some extent, as he believed he was vulnerable. Officers told the investigator that the man was easily influenced by other prisoners and that they thought this was probably why he had joined in the attack on the prisoner.

70. Staff were not originally aware of the first assault on the prisoner, which took place before 10.00am. After he was assaulted at 11.20am, Officer A was about to review the CCTV from the second assault when the third attack on the prisoner occurred. This disturbance involved a larger group of prisoners and some were locked in their cells as they continued to behave aggressively when officers tried to control the situation. The officer could not recall whether the man had been involved in the third incident, although Prisoner A said that he was. Shortly after this disturbance, Prisoner A assaulted the man. Officer A and a colleague did not know until they watched the CCTV that the man had been involved in the second assault on the prisoner.

71. Whether or not Prisoner A had planned to assault the man that morning (and it seems unlikely that this was a premeditated attack), we do not consider that there was any reason why prison staff should have identified that the man was at risk from him. Issues about bullying, debt, and violence should have been dealt with more robustly before 12 October and it is very concerning that so many violent incidents happened in such a short space of time that morning. However, we consider that officers acted appropriately on the morning of 12 October to try to control the situation on the wing and could not have anticipated or prevented the man's actions.

Bullying

72. New psychoactive substances are an increasing problem in prisons nationally. As well as evidence of dangers to physical and mental health, we have seen many examples where trading in these substances leads to debt, violence and intimidation. There was information that the man used NPS and the post-mortem examination confirmed this.

73. Staff and prisoners said that the man was in debt to other prisoners due to his use of NPS and there were intelligence reports about this. Officers had found him with items in his cell, such as mobile telephones or NPS, which he said he had been bullied into keeping for other prisoners, as he owed them money for drugs. He also told staff that he was being threatened by other prisoners in his workshop. Prisoner A said that he was aware that other prisoners had assaulted the man, as he had not paid his debts for drugs. He said that the confrontation between a prisoner and other prisoners on 12 October was about a debt another prisoner owed this prisoner for NPS. We have found no evidence that the man was in debt to this prisoner or Prisoner A.

74. On 6 September 2014, the man's ACCT document indicated that he had identified the prisoners who he claimed were threatening him, yet there is no evidence that staff acted on this information. We could find no record of who these prisoners were. All the staff the investigator spoke to said that violence reduction procedures should have begun at this point to support him, but this was not done. Opportunities to support him through ACCT procedures were missed. A custodial manager, acting on his own, ended ACCT procedures a week later, which was inappropriate. An action identified to reduce his risk had not been completed and healthcare staff had not been involved. The ACCT procedures did not operate effectively to support him and help resolve his problems with other prisoners. (As we are not investigating a self-inflicted death, we do not make a formal recommendation about the ACCT procedures, which were very poor, but the Governor will need to address the deficiencies identified.)

75. On 22 September, the man's cellmate said that the man had made him perform sexual acts at knifepoint. Staff moved his cellmate to another wing and he transferred to another prison a week later and said he wanted the matter referred to police. The man's record indicated that he would be subject to violence reduction monitoring. On 29 September, when a SO noted that no one had recorded any monitoring in the document, she ended the violence reduction procedures, rather than requiring staff to monitor him properly. This is very concerning after his cellmate had made such a serious allegation. The prison was unable to supply the document and there is no evidence that staff investigated the matter or informed the police.

76. Rochester's Violence Reduction Policy instructs all staff to investigate and challenge allegations of bullying and unacceptable behaviour. We are concerned that no one properly investigated the man or his cellmate's allegations at the time, or took any action, despite the existence of security information to support them. At the inspection of Rochester in September 2015, HM Inspectorate of Prisons noted that the prison's response to dealing with a significant problem of debt and

violence had been ineffective, and recommended urgent action to tackle it. We make the following recommendation:

The Governor 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 associated debt. All allegations of violence, bullying, or intimidation should be taken seriously and investigated appropriately. Suspected perpetrators should be monitored and challenged through effective interventions and potential victims supported as part of a robust violent reduction strategy.

New psychoactive substances

77. The post-mortem examination found that the man was a habitual user of NPS. Staff and prisoner accounts supported this and, as noted above, he appears to have been in debt to other prisoners and threatened because of this.

78. We were concerned about the extent of the availability and use of NPS and other illegal substances at Rochester, at the time of the man's death. HM Inspectorate of prisoners also identified this as a significant concern. However, we recognise that since his death, Rochester has introduced a new drug strategy, aimed at reducing demand and supply. The prison has improved fencing around the perimeter wall in an effort to reduce 'throw overs' and now has two search dogs trained to detect NPS. Rochester said they take a robust approach to help in bringing criminal charges against those found to be involved.

79. To try to give prisoners appropriate information and to help reduce demand for NPS, Rochester commissioned a film from a charity working with ex-offenders about the effects of NPS. This is shown to all new prisoners. The charity completed a survey at Rochester to establish why prisoners use NPS. The prison is now incorporating the results into their drug strategy. The prison has also started "suspicion testing", as they have found that prisoners often use NPS with other drugs that can be detected. (An accurate test is not yet available for NPS in prisons.) When prisoners tests positive, they are referred to substance misuse services and support to stop using NPS. We are satisfied that Rochester had recognised the scale of the problem with NPS and is taking steps to help reduce both supply and demand for NPS at the prison. We therefore do not make a recommendation.

Clinical care

80. The clinical reviewer who reviewed the man's clinical care at the prison, noted that in the weeks leading up to his death, he had largely stopped taking antidepressants. However, the clinical reviewer did not consider that this was detrimental to his mental health. He noted that the man's main problems were his use of several different drugs, possible post-traumatic stress disorder, impulsivity and his self-harming behaviour. He considered that the effect of sertraline would only have been marginal.

81. The clinical reviewer noted that healthcare staff in different prisons had tried to help the man control his anxiety, not take drugs, improve his problem solving skills, and reduce his impulsivity. Mental health nurses, psychologists and

psychiatrists had assessed him in the past. They had diagnosed him with behavioural problems and personality disorders but not mental illness. He concluded that his medical care was equivalent to that he would have expected to receive in the community.

Emergency response

82. Prison Service Instruction (PSI) 03/2013 requires that the Governor must have a medical emergency response code protocol that ensures that an ambulance is called automatically in a life-threatening medical emergency. The protocol gives guidance on efficiently communicating the nature of a medical emergency, ensuring that staff take the correct equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. Governors are required to have a two code medical emergency response system based on the instruction. Rochester uses code blue to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. The control room should call an ambulance when an emergency code is used.

83. Prisoner 1 believed the man was knocked unconscious by Prisoner A's punch. By the time prison staff attended a short time later, he was still on the floor but not unconscious. An officer pressed the general alarm rather than using her radio, as she said this was a quicker way to get help. She said nurses would normally attend a general alarm but if not, they could be called by radio or telephone. There does not appear to have been a delay in nurses attending and they brought emergency equipment with them. An officer said he did not consider radioing an emergency code, as he was preoccupied with trying to keep the man in the recovery position.

84. When a nurse assessed the man, she asked an officer to call an ambulance. At 11.40am, seven minutes after the assault, control room staff asked whether an ambulance was needed. She said in her opinion it was reasonable that staff had not called an ambulance immediately, as the man was conscious and his vital signs were normal. The clinical reviewer agreed.

85. While we accept that it was not immediately apparent to staff that the man needed an emergency ambulance, we are concerned that there was a delay in calling one after the nurse asked for one. It should not have been necessary for the control room to check. We are also concerned that the staff we interviewed were not clear about the use of the emergency code system and whose responsibility it was to call an ambulance. We have made previous recommendations about delays in calling ambulances in investigations reports into deaths at Rochester in October 2014 and May 2015. After the May 2015 death at Rochester, the Governor re-issued a notice to staff reminding them about the emergency code system. However, during their inspection in September 2015, inspectors still found a number of staff were unaware of the medical emergency code system. It is evident that the Governor needs to do more to ensure that staff understand and follow emergency procedures. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013, the local protocol, and their responsibilities during medical emergencies and that:

- **Staff efficiently communicate the nature of a medical emergency using the appropriate code;**
- **The control room calls an ambulance as soon as an emergency medical code is received, or an ambulance is requested.**

The man's sedation

86. The man's partner's mother told our family liaison officer that she saw a prison officer adjusting the man's level of sedation at the hospital. The investigators referred this matter to the police, who spoke to a consultant anaesthetist who had been involved in looking after him at the hospital. He indicated that even if an officer had attempted to adjust the level of sedation, it would not have caused him any harm. The police decided to take no further action.

87. We contacted the Governor of Rochester. He also made enquires but concluded that there was not sufficient evidence for a disciplinary investigation.

Restraints

88. When prisoners have to travel outside prison, a risk assessment determines the nature and level of any security arrangements. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. The level of any restraints used should be necessary in the circumstances and take into account the risk of escape, the risk to the public and factors such as the prisoner's health and mobility.

89. Two managers told the investigators that they had completed a risk assessment. Despite several requests, we have not seen this document. However, we are satisfied that the use of an escort chain was appropriate. At the time he was taken to hospital, the man walked to the ambulance, was agitated and resisting treatment. Restraints were removed quickly in hospital. Officers remained with him in hospital, which was reasonable, but he was not restrained after that.

Informing the police of the assault on the man

90. PSI 47/2011, Prisoner Discipline Procedures, states that if a serious criminal offence appears to have occurred the police should be contacted immediately. We are concerned that the prison did not inform the police of the assault on the man until four hours later. Although staff would not have known at that stage that his injuries would be fatal, it was evident that he had been seriously injured and another prisoner was responsible. We consider that as soon as he was taken to hospital, the prison should have informed the police. (We also note that his cellmate's serious allegations were not referred to the police.)

91. The Head of Intelligence and Security, and a custodial manager told the investigators that, immediately after the assault, their focus was on the man and the security and good order of the prison. They did not consider four hours an unreasonable amount of time to contact the police. We do not consider that a

delay of four hours was reasonable and we do not consider it met the requirement in the PSI that the police should be informed immediately. We make the following recommendation:

The Governor should ensure that when a prisoner is seriously assaulted, the police are notified without delay, in line with PSI 47/2011.

Liaison with the man's family

92. Soon after the man arrived at hospital, he was diagnosed with a cracked skull and bleeding on the brain and put into an induced coma. 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".

93. The man had named his partner as his next of kin, but there were five different mobile telephone numbers for her in his recent prison record. The Head of Safer Custody telephoned the most recent number in the man's records on 12 October and left a message asking her to contact the prison. He told the investigators that he did not think that contacting the man's partner was urgent as he did not believe his condition was life threatening. He did not appoint a family liaison officer as he wanted to wait until they contacted his family. Officer A said he had advised him that someone should visit the family in person.

94. Over the following two days, Officer A and another officer continued to try to contact the man's partner. Officer A checked the numbers the man had called on the prison telephone system but did not think there was any point in calling numbers that had not been answered when the man called them, as he thought they must no longer be in use. Both officers said that they tried to contact his family, as they thought this was urgent. They considered a family liaison officer should have been appointed immediately to make more concerted efforts to contact the family. It took three days to contact the man's partner's mother and then the Head of Safer Custody appointed an officer as family liaison officer.

95. While we understand that some efforts were made to contact the man's family, much of this relied on the good will of officers with other duties. He was seriously ill in hospital and we consider that the prison should have appointed a family liaison officer immediately with sufficient resources to prioritise contacting his family, including by visiting them in person. It is important that there is no delay contacting families when a prisoner is seriously ill in hospital, as this can result in families missing the opportunity to see a loved one before they die. We make the following recommendation:

The Governor 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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