Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Arthur Morley a prisoner at HMP Grendon on 18 December 2015

**A report by the Prisons and Probation Ombudsman**
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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.

Mr Morley was found hanged at HMP Grendon on 18 December 2015. He was 72 years old. I offer my condolences to Mr Morley's family and friends.

Grendon is an unusual and impressive prison run as a number of therapeutic communities. A few hours before his death, prison staff had told Mr Morley that, after an assessment period, he had been found unsuitable for therapy. Mr Morley was upset about the decision but several members of staff spoke to him afterwards, and concluded that he did not need to be monitored as at risk of suicide or self-harm. A multi-disciplinary healthcare team meeting drew the same conclusion. Despite his later actions, I consider that the staff made a reasonable and considered decision not to begin monitoring procedures.

Grendon does not have in-cell sanitation and Mr Morley hanged himself at night in the wing communal lavatory facilities. While I recognise that prisoners can also come to harm in their cells, I consider that the prison needs more effective procedures to check the safety of prisoners who have been out of their cells for extended periods at night.

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

**Nigel Newcomen CBE**
**Prisons and Probation Ombudsman** **July 2016**

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# Summary

## Events

1. In 2008, Mr Arthur Morley was sentenced to an indeterminate sentence for public protection with a minimum period to serve of 26 months (known as the 'tariff'). The Parole Board had never considered him suitable for release. He first moved to HMP Grendon (a prison that operates on therapeutic community principles) in March 2012. He did not complete his therapy and left the prison in January 2014. Mr Morley applied to Grendon for a second time and was accepted for a period of assessment. He moved to Grendon on 24 August 2015.

2. Mr Morley was admitted to G Wing, the induction and assessment unit, where new arrivals live until prison staff and therapists assess them as suitable for one of the five therapeutic communities. On 17 December, the therapy manager and two supervising officers told Mr Morley that they had not found him suitable for therapy and he would have to go back to his previous prison. Mr Morley was shocked and upset at the news. Staff said that his reaction was not unusual.

3. Several staff and prisoners spoke to Mr Morley that afternoon. They told us that, although he was upset, he appeared to have accepted the decision and said he would think about applying to Grendon again. The therapy manager and healthcare staff discussed Mr Morley's risk and concluded that they did not need to begin Prison Service suicide and self-harm prevention procedures.

4. Cells at Grendon do not have integral sanitation. When prisoners need to use the toilet at night, their cells are unlocked electronically to allow them to use the communal facilities on each spur. At around 12.30am on 18 December, a night patrol officer and the control room operator realised that Mr Morley had been out of his cell for around 80 minutes. The night patrol officer could not see Mr Morley from the end of the locked spur. The night manager came, opened the spur and found Mr Morley hanged in the toilet area. Prison staff began cardiopulmonary resuscitation. Paramedics arrived and, after further emergency treatment, recorded that Mr Morley had died.

## Findings

5. Mr Morley was some years past his tariff. Earlier in 2015, the Parole Board had recommended that Mr Morley should complete therapy at Grendon and he would have recognised the decision not to accept him for therapy as a further setback to his prospects of release. He was evidently upset by the decision and prison staff recognised and discussed his risk of suicide in the light of this news. We are satisfied that, although this turned out to be wrong, the staff made a reasonable and considered decision at the time, not to begin suicide and self-harm prevention procedures. However, we consider that the night patrol officer and control room operator should have summoned help more quickly when they realised that Mr Morley had been out of his cell for so long. The prison needs better procedures for checking prisoners who have been out of their cell for an extended time at night.

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## Recommendation

- The Governor should ensure that Grendon has appropriate procedures to identify and respond when prisoners have been out of their cells for an extended time at night, and that night patrol officers inform the night manager immediately if they have concerns for the safety of an individual.

## The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Grendon, informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded.

7. NHS England commissioned a clinical reviewer to review Mr Morley's clinical care at the prison.

8. The investigator visited Grendon on 30 December 2015. He obtained copies of relevant extracts from Mr Morley's prison and medical records, and interviewed five prisoners. He later spoke to another prisoner by telephone.

9. On 4-5 February, the investigator interviewed eight members of staff, and the prisoner who had contacted him, at Grendon. The clinical reviewer joined him for some of the interviews.

10. We informed HM Coroner for Buckinghamshire of the investigation, who gave us the results of the post-mortem examination. The coroner has been sent a copy of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Morley's friend, who he had named as his next of kin, to explain the investigation. Mr Morley's friend asked whether prison staff should have monitored him more closely after they told him he was unsuitable for therapy. The family liaison officer also contacted Mr Morley's son, who did not have any specific matters for the investigation to consider.

12. Mr Morley's friend and son both received copies of the initial report. Mr Morley's friend raised some issues that do not impact on the factual accuracy of the report and have been addressed through separate correspondence. Mr Morley's son did not make any comments.

# Background Information

## HMP Grendon

13. Grendon holds up to 238 men and accepts prisoners serving indeterminate sentences or determinate sentences with at least two years left to serve. It is run on democratic therapeutic principles. It has six wings, five of which operate as autonomous therapeutic communities. The sixth, G Wing, is an induction and assessment wing.

14. Care UK provides healthcare services from 8.00am to 7.00pm from Monday to Friday, and 9.15am to 5.00pm at weekends. Oxford Health NHS Foundation Trust provided secondary mental health services until 1 April 2016, after which Barnet, Enfield and Haringey Mental Health NHS Trust assumed the contract.

## G Wing

15. New arrivals at Grendon go to G Wing, the induction and assessment unit, for around three to six months. During their time on G Wing, prisoners attend wing meetings on Mondays and Fridays and small group sessions on Wednesdays. At the meetings and group sessions, prisoners are encouraged to talk freely about issues on the unit. They do not discuss issues about their offence until they move to a therapy wing. Throughout a prisoner's time on the unit, wing officers and therapists assess their progress to determine whether they are suitable for therapy. Prisoners have a first progress report after four to six weeks and a second progress report after around three months. Most prisoners are told at the second progress report whether they have been accepted for a place in therapy or have to go back to their original prison. Some have an extended period of assessment. All wing officers receive Therapeutic Communities Awareness Training. Decisions on whether to allocate to a therapy wing are made jointly by wing officers and therapists.

## Electronic night sanitation

16. Cells at Grendon do not have toilet facilities. When prisoners want to use the toilet at night they press a button in their cell and join a queue if others are waiting. Cells are electronically unlocked and only one prisoner on each spur can be unlocked at a time. When they return to their cell, the next prisoner is unlocked. An alarm sounds in the control room when a prisoner has been out of their cell for six minutes. The control room operator must then press a button to acknowledge and stop the alarm. If a prisoner has been out of their cell for 12 minutes, the control room operator receives a message on their computer screen and the prisoner cannot use the system again that night unless an operator specifically authorises it. There is no alarm after 12 minutes, the operator is not required to acknowledge the message and they remain on the screen for a limited time before they are replaced by newer messages.

## HM Inspectorate of Prisons

17. The most recent inspection of HMP Grendon was in August 2013. Inspectors reported that violent incidents were rare, that prisoners trusted staff and did not hesitate to discuss and resolve issues about their safety. Grendon rarely used

anti-bullying procedures and incidents were resolved through discussion at wing meetings and group sessions. Inspectors reported that levels of self-harm were low and the use of safer custody representatives to help support those in crisis had improved. They found that staff were aware of potential triggers for suicide and self-harm and that relationships between staff and prisoners were exceptionally good.

### Independent Monitoring Board

18. 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. There is no recent published IMB annual report. In the report, for the year to December 2012, the IMB reported that staff at Grendon were highly committed to all aspects of safer custody and there was good co-ordination between managers, staff and prisoner safer custody representatives. They considered that Grendon was a safe environment with low levels of bullying.

### Previous deaths at HMP Grendon

19. Mr Morley's was the first apparent self-inflicted death Grendon since 2009, and only the second since the Ombudsman began investigating deaths in prisons in 2004. There was a homicide at the prison in 2010. Another prisoner died at Grendon in 2015, from natural causes. There were no significant similarities with the other deaths.

### Assessment, Care in Custody and Teamwork

20. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

# Key Events

21. In June 2008, Mr Arthur Morley was convicted of distributing indecent photographs of children. He was sentenced to an indeterminate sentence for public protection (IPP) with a minimum period to serve (the 'tariff') of 26 months. This was his fourth prison sentence for a sexual offence. He told a prison doctor that he tried to kill himself before his conviction but he was not assessed as at risk of suicide or self-harm at any time in prison.

22. In March 2012, Mr Morley transferred to Grendon, as he had a sentence plan target to engage in intensive therapy to reduce his risk of reoffending. After an initial assessment, he moved to one of the therapeutic communities. However, he was 'voted out' of the community in December 2013, after he breached confidentiality by discussing issues raised in group sessions and meetings with prisoners from another community. ('Voting out' is a process where other members of the community can vote to remove someone if they consider they have broken the community's constitution.) Mr Morley initially found it difficult to cope with his deselection. The prison's mental health inreach team supported him for a short time and a GP prescribed antidepressants. In January 2014, Mr Morley transferred to HMP Ashfield, and decided to stop taking antidepressants shortly afterwards.

23. During his time at Ashfield, Mr Morley often complained about other prisoners playing loud music. In September 2014, he referred himself to Ashfield's mental health inreach team and said he found it difficult to deal with his emotions from trying to come to terms with his offence. After several individual sessions over the following two months, Mr Morley was discharged from the service because the team considered that his mood and ability to control his emotions had significantly improved.

24. After a hearing in February 2015, the Parole Board recommended that Mr Morley should have further therapy at Grendon. Grendon accepted him for assessment and he was admitted to G Wing, the induction and assessment unit, on 24 August.

25. The lead nurse for Grendon completed a routine health screen on 26 August. He remembered Mr Morley from his previous time at Grendon, and said that Mr Morley seemed happy to be back and told him some stories of his first time at the prison. He asked Mr Morley whether he had harmed himself in the past, and Mr Morley said he had taken an overdose in the community around 20 years earlier, following the break-up of a relationship. He said that he had previously taken antidepressants for one month, but had stopped because he did not like taking medication. He did not refer Mr Morley to a prison GP or to the mental health inreach team. He said that Mr Morley was happy to be at Grendon and was positive about the future.

26. On 19 October, Mr Morley attended for his first progress report with a forensic psychologist and two Supervising Officers (SOs). They noted that Mr Morley had made a concerted effort in groups and on the wing, but sometimes displayed both controlling and people-pleasing behaviour.

27. On 3 November, Mr Morley wrote a note in which he said he felt stressed, depressed and desperate to move to a therapy wing to talk about his problems. He said that his crimes weighed heavily on him and he found it hard to think about the impact on his victims. Mr Morley found the noise of other prisoners' music relentless, said he was alone, had no future and he knew what the answer was. Mr Morley did not address the note to anyone and there is no indication that any member of staff saw it. The police found it in his cell after his death.

28. On the evening of 8 November, Mr Morley argued with his neighbour about the volume of his neighbour's music. Mr Morley wired up a plug socket to blow the power on the spur and prevent his neighbour from playing music. An SO charged him with a disciplinary offence of intentionally endangering the health or personal safety of others. He told us that Mr Morley was aggressive towards his neighbour and threatened that he would make sure that his neighbour was removed from Grendon.

29. The next morning, two SOs spoke to Mr Morley about the incident. Mr Morley repeatedly said that his neighbour had bullied him, so they began an anti-bullying support plan, although both considered that Mr Morley might be the aggressor. Mr Morley was moved to a different spur, away from his neighbour.

30. The Head of Residence was the adjudicator at Mr Morley's disciplinary hearing on 10 November. Mr Morley pleaded guilty and he punished him with seven days' loss of privileges (such as access to the gym and ability to buy items from the prison shop) and a 50 per cent reduction in earnings from his work. (Mr Morley was a wing cleaner.)

31. Later on 10 November, an SO reviewed Mr Morley's anti-bullying support plan. Mr Morley acknowledged he had done wrong, and said he felt stressed and had not been able to express his feelings. He said that moving cell had helped. The SO recorded that Mr Morley continued to minimise his actions and had not acknowledged that he had threatened the other prisoner.

32. On 11 November, Mr Morley and his former neighbour attended the same small group meeting. The psychologist recorded in the anti-bullying support plan that they had worked well together to develop learning from the incident. She recorded that Mr Morley apologised and acknowledged that he had bullied his neighbour to try to get his own way. In Mr Morley's group notes, she noted that he also presented himself as a victim.

33. On 18 November, two SOs reviewed Mr Morley's anti-bullying support plan. Mr Morley said he had discussed the incident at his small group and at wing meetings. He said he did not feel threatened by his former neighbour and could see his part in the matter. Both SOs stopped monitoring him under the support plan.

34. On 2 December, Mr Morley argued with another prisoner. An SO recorded that the prisoner had said Mr Morley challenged others for behaviour that he was guilty of himself.

35. On 4 December, the G Wing safer custody representative (an elected position that involves looking out for the welfare of other prisoners on the wing) spoke to

Mr Morley. He recorded that Mr Morley felt "down in the dumps" and said that he needed to start working on issues relating to his offence but could not do so until he moved to a therapy wing.

36. On 7 December, Mr Morley phoned two friends. Prisoners' telephone calls are recorded and we listened to recordings of Mr Morley's calls. (Unless there are security grounds to target calls, prison staff listen to a random sample of telephone calls, but they had not listened to Mr Morley's.) Mr Morley told his friends that he was keen to move to a therapy wing so he could speak about his emotions. Mr Morley said he had written to his son some weeks ago but had not heard back from him. (Mr Morley had not had any contact with his son for some time.)

37. On 10 December, the safer custody representative spoke to Mr Morley again. He recorded that Mr Morley felt much better.

38. On an unknown date in December, Mr Morley reportedly tampered with an electric socket in his cell to allow him to use an additional electrical appliance. Most staff and prisoners we spoke to were aware of this incident, although no one recorded it in Mr Morley's prison records and no one charged him with a disciplinary offence.

39. An SO and the psychologist led Mr Morley's small group on 16 December. They recorded that he did not engage well, went off topic and did not discuss his own issues. They noted that his behaviour was poor. Wing staff had given Mr Morley similar reports after previous group meetings, although they sometimes gave more positive feedback.

40. In the afternoon, Mr Morley phoned his two friends. He told one that he felt really good and the other that he was making progress and could not wait to move to a therapy wing.

41. About midday on 17 December, Mr Morley attended a second meeting to review his progress with the therapy manager and two SOs. They told Mr Morley that they had not found him suitable for therapy and he would have to return to Ashfield. The therapy manager told us that they found Mr Morley unsuitable because he continued to display similar negative behaviour to his previous time at Grendon, such as controlling behaviour and a failure to take responsibility for his actions.

42. One SO said Mr Morley was angry and emotional when they told him the news and left the meeting before the end. The therapy manager recorded that he said, "You fucked my life up. There is nothing for me now". She and an SO said that they did not find anything unusual in Mr Morley's reaction to the news that he had not been selected for therapy and it was quite normal for prisoners in this situation to become emotional.

43. After the meeting, Mr Morley telephoned one of his friends and left a voicemail message. He said that the news was a "hell of a shock" and he did not know what he would do next. As previously, prison staff did not monitor the call.

44. Shortly after the meeting, an SO asked Mr Morley to speak to wing staff again later in the day, when he had had some time to think things through. Mr Morley

said he was fine, although the SO said he appeared frustrated. The SO told the safer custody representative about Mr Morley's news and asked him to speak to Mr Morley. The representative said that Mr Morley was initially angry and frustrated but, later in the conversation, seemed as if he had come to terms with the decision. Mr Morley told him he would speak to an SO to see if the decision could be overturned.

45. After lunch, Mr Morley telephoned his other friend. He explained the decision and the reasons behind it. He said he was "totally gutted" about it.

46. The SO spoke to Mr Morley later in the afternoon. Mr Morley said he was angry about the decision but he would go back to Ashfield and think about applying to Grendon again.

47. In the afternoon, healthcare staff held a weekly multi-disciplinary team meeting, including nurses, doctors and therapists. The therapy manager and lead nurse both attended. The aim of the meeting was to discuss and share information about any prisoners who had new or complex needs. This included prisoners who had recently been told they were unsuitable for therapy. The therapy manager told the meeting that Mr Morley had not taken the news that he had not been selected very well. They discussed Mr Morley's mental health history and previous self-harm in the community. They noted that he had not previously been managed under ACCT procedures in prison. The lead nurse said they also noted that Mr Morley had told wing staff that he would think about reapplying to Grendon. He said they discussed whether to begin ACCT procedures but the meeting agreed this was not necessary.

48. Shortly after 5.00pm, Mr Morley phoned the friend he had left a message with earlier. He explained what had happened and said he would try to get through it and do the best he could. Mr Morley then attended the prison's Christmas carol service, where he gave a reading. Prisoners who attended the service said that Mr Morley seemed his normal self.

49. A prisoner spoke to Mr Morley after the service. Mr Morley told him that he had to go back to Ashfield but might reapply to Grendon in the future. The prisoner told us that Mr Morley seemed upset but was quite 'matter of fact' about the news and appeared positive about the future.

50. Around 7.10pm, Mr Morley spoke to the safer custody representative. He said that Mr Morley was quite insistent that they should speak and gave him a full bag of coffee, which he said he did not drink anymore. At 7.15pm, an SO locked Mr Morley in his cell for the night and said she asked Mr Morley if he needed any support. Mr Morley said he did not and would see her tomorrow.

51. At 8.45pm, an operational support grade (OSG), the night patrol officer, started work on G Wing. The OSG said that he checked the wing observation book at the start of his shift and saw that Mr Morley had been told he was not suitable for therapy. There was no instruction that he should specially check Mr Morley that night. He checked all the prisoners were in their cells, but could not remember what Mr Morley was doing at the time.

52. The night patrol is required to patrol the wing four times during the night. While staff are on the wings at night, prisoners are not allowed out of their cells under the electronic unlock system. The OSG completed his first patrol at around 11.15pm. He said this was uneventful.

53. At 11.18pm, Mr Morley left his cell using the electronic unlock system. He did not return within six minutes and an alarm therefore sounded in the control room. The control room operator told us he did not remember hearing or accepting the alarm and he did not notice the 12-minute message before it was replaced by newer messages.

54. At around 12.30am, a prisoner on Mr Morley's spur contacted the OSG by the cell intercom to ask why he could not get out of his cell to use the toilet. The OSG phoned the control room operator and they realised that Mr Morley had been out of his cell for around 80 minutes. The OSG tried to contact Mr Morley using the cell intercom, but got no response. He went to the spur and saw that Mr Morley's cell door was open, but he could not see Mr Morley.

55. The OSG told the control room operator, who telephoned a member of the night team who respond to incidents around the prison. The control room operator told him that a prisoner had been out of his cell for 80 minutes and asked someone to visit G Wing to investigate. The officer radioed the night manager and told him what had happened. This call was recorded at 12.41am.

56. The night manager joined the rest of the night team and went to G Wing. When they arrived, at 12.48am, he radioed the control room operator and asked him to override the electronic lock on Mr Morley's spur. They went to Mr Morley's cell and found nothing. They then went to the spur toilet where they found Mr Morley hanging from his dressing gown cord, which he had tied to a pipe above the door. The night manager cut the cord and laid Mr Morley on the floor. He radioed the control room operator and asked him to call an ambulance. The control room operator made the call immediately.

57. Two officers began chest compressions. They attached a defibrillator, which found no shockable heart rhythm so they continue chest compressions. Paramedics arrived on G Wing at 1.16am and took over emergency treatment. At 1.40am, they recorded that Mr Morley had died.

58. As well as the note of 3 November, the police found two other notes in Mr Morley's cell. Mr Morley had addressed the first note to his friend, named him as his beneficiary and thanked him for his friendship. He wrote that he could not see any future following his deselection. Mr Morley addressed the second note to the staff on G Wing who "voted me out", thanked them for this Christmas present and wrote that Grendon had been his "last chance".

### Contact with Mr Morley's family

59. Mr Morley had named a friend as his next of kin. Two prison family liaison officers visited him at around 7.00am on 18 December and informed him of Mr Morley's death. Mr Morley's friend said he was in contact with Mr Morley's son and that he would inform him of his father's death. A family liaison officer contacted Mr Morley's son afterwards. Mr Morley's funeral was held on 11

January 2016. In line with Prison Service instructions, the prison contributed to the costs.

### Support for prisoners and staff

60. After Mr Morley's death, the Head of Residence debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

61. G Wing staff held a special meeting for all prisoners on 18 December, to allow anyone affected to discuss what had happened. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Morley's death.

### Post-mortem report

62. A post-mortem established the cause of death as suspension.

# Findings

### Identification of risk of suicide and self-harm

63. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, says that all staff who have contact with prisoners must be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Grendon should have recognised Mr Morley as at risk on 17 December, and started ACCT monitoring.

64. Some of these risk factors applied to Mr Morley. He had harmed himself in the past, although this was some years ago and not in prison. He had had contact with prison mental health services, although for relatively brief periods and not during his second time at Grendon. Mr Morley had also alleged that another prisoner had bullied him at Grendon. Most significantly, G Wing staff told him on the day of his death that he was unsuitable for therapy and that he would have to go back to his original prison. The notes Mr Morley left indicate that this decision was the trigger for his actions.

65. Mr Morley was angry and upset when G Wing staff told him of his deselection, and he left the meeting early. The staff who attended the meeting told us that there was nothing unusual about his reaction. Both SOs spoke to Mr Morley that afternoon, and they alerted the wing safer custody representative. Mr Morley told one SO that he would go back to Ashfield and think about applying to Grendon again. (Mr Morley also told other prisoners this.) The therapy manager and healthcare staff discussed Mr Morley's mental health and risk of suicide and self-harm in a meeting that afternoon. They considered whether to start ACCT procedures and concluded that this was not necessary.

66. Staff judgement is fundamental to the ACCT system. The system relies on staff using their experience and skills, as well as local and national assessment tools to determine risk. PSI 64/2011 lists a change in status as a potential trigger for suicide or self-harm. Although Mr Morley received unexpected and unwelcome news on 17 December, prison staff acknowledged this and discussed his risk factors. They thought that Mr Morley had considered his future and what he might do when he returned to Ashfield.

67. As an indeterminate sentenced prisoner some years past tariff, Mr Morley had been relying on taking part in therapy at Grendon to make progress towards release but this route had been denied him. With the benefit of hindsight, staff appear to have underestimated the extent of his distress. However, we consider they properly considered his risk and made a reasoned decision at a multidisciplinary meeting not to monitor Mr Morley under ACCT procedures. We do not criticise that judgement.

### Operation of night sanitation

68. Local instructions at Grendon explain what to do when an alarm sounds in the control room to indicate a prisoner has been out of their cell for six minutes. The control room operator should notify the night patrol officer on the relevant wing

who should check that the prisoner is safe. The night patrol officer should monitor and ensure that the prisoner returns to their cell within a reasonable time, usually no more than 15 minutes. The instructions state that, if the night patrol officer is concerned about the safety or conduct of an individual, or they have not returned to their cell within a reasonable time, then they should notify the night manager who will take further action.

69. The control room operator said he did not remember an alarm activating when Mr Morley had been out of his cell for six minutes. He said that his understanding of local policy was that the control room operator should accept the six-minute alarm but did not have to take any action until a prisoner had been out of his cell for 15 minutes, when he should contact the night patrol officer on the relevant wing. However, neither he nor the OSG realised that Mr Morley had been out of his cell for an extended period. The control room operator said that alarms went off frequently and it was very easy to overlook that someone might have been out of his cell for too long. After Mr Morley's death, the Governor commissioned a disciplinary investigation into their actions. He dismissed the OSG from the Prison Service and issued the control room operator a final written warning.

70. We obtained figures for the number of audible alarms triggered when prisoners were using toilet facilities at night for the final week of February 2016. Across the prison, there was an average of 87 alarms from 9.00pm to 12.00am each night. (This includes some alarms for reasons other than a six-minute absence such as a door lock failure.) The staff did not adhere to the local instructions, but we consider it would be very difficult with the current system for control room and night patrol staff to note and respond to this many events. With no additional alarm after the six-minute period, and the 12-minute message only available to the operator for a limited time, it seems almost inevitable that some prisoners will be overlooked.

71. The Governor told us that he is investigating the cost implication of adding a second audible alarm when a prisoner has been out of their cell for 15 minutes and, depending on the outcome, will consider whether to add a second alarm or alter the time of the initial alarm. We understand that changing the time of the initial alarm is a straightforward process that takes a few minutes to complete.

72. We are also concerned that there was a delay of several minutes before the control room operator and OSG notified the night team that Mr Morley had been out of his cell for over an hour. Local instructions are that they should contact the night manager when a prisoner has been out of their cell for an unreasonable amount of time, usually around 15 minutes. In these circumstances, they should have informed the night orderly officer as soon as they identified that Mr Morley had been absent for some time. We make the following recommendation:

**The Governor should ensure that Grendon has appropriate procedures to identify and respond when prisoners have been out of their cells for an extended time at night, and that night patrol officers inform the night manager immediately if they have concerns for the safety of an individual.**

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