

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Liam Clerkson, a prisoner at HMP Durham, on 6 August 2018

A report by the Prisons and Probation Ombudsman

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*



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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 Liam Clerkson died in hospital on 6 August 2018, three days after collapsing in his cell at HMP Durham. He died from the effects of psychoactive substances (PS). He was 27 years old. I offer my condolences to Mr Clerkson's family and friends.

Mr Clerkson was found collapsed in his cell a few hours after arriving at Durham. Drug paraphernalia was found in his cell and after Mr Clerkson had been taken to hospital, several drug packages were found secreted inside his body.

While prison staff responded quickly when they found Mr Clerkson unresponsive, the clinical reviewer found that the healthcare response was inadequate and that resuscitation was not carried out in line with guidance. It is not possible to say what impact, if any, this had on the eventual outcome for Mr Clerkson.

I have previously expressed concern that experienced prisoners, rather than an appropriate member of staff, assess newly arrived prisoners at Durham and recommend whether they should be referred to the prison's Drug and Alcohol Recovery Team. The investigation found this practice was still happening. I therefore repeat my previous recommendation.

I am aware that since Mr Clerkson's death, Durham has made good progress in tackling the supply of drugs in the prison, including the installation of a body scanner. This should mean that it is now far harder for prisoners to smuggle drugs into the prison through reception as Mr Clerkson did.

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

Sue McAllister CB
Prisons and Probation Ombudsman

January 2020

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Summary

Events

1. On 3 August 2018, Mr Liam Clerkson was sentenced to six months in prison, charged with possession of an offensive weapon. He was sent to HMP Durham.
2. Mr Clerkson arrived at Durham at around 6.00pm. Reception staff thought he appeared agitated. At his initial health screen, Mr Clerkson tested positive for drugs, including cocaine and cannabinoids. He told staff he had a problem with drugs and agreed to be referred for support. A GP reviewed his record, including the positive drugs test, and noted that she would refer him to the detoxification clinic.
3. Mr Clerkson was placed in a shared cell at around 9.20pm. His cellmate entered the cell 15 minutes later.
4. At around 10.00pm, during a roll check, an officer noticed that Mr Clerkson's cellmate was standing near the toilet area of the cell, looking very worried. He was calling to Mr Clerkson but not getting a response. The officer called for assistance and two other officers responded. They entered the cell and found Mr Clerkson slumped by the toilet. The officer called a medical emergency code and several staff responded, including two nurses.
5. One of the nurses threw water into Mr Clerkson's face. The other nurse then said they needed more space to start cardiopulmonary resuscitation (CPR) and so prison staff moved Mr Clerkson out of the cell onto the landing. Staff carried out CPR until ambulance paramedics arrived.
6. Two ambulances arrived just after 10.14pm. Paramedics took Mr Clerkson to hospital. Two officers escorted Mr Clerkson and they did not restrain him.
7. Mr Clerkson never regained consciousness and died in hospital on 6 August.
8. After Mr Clerkson's death, his cellmate told police that Mr Clerkson had been acting "like a zombie" when he entered their cell. He said that Mr Clerkson appeared to have been under the influence of drugs in reception that evening. He had also seen Mr Clerkson take a 'Kinder egg' (the plastic container inside a Kinder egg chocolate) containing tablets out of his trousers. Mr Clerkson had taken some and handed others out to other prisoners.
9. The post-mortem report concluded that Mr Clerkson died from the effects of psychoactive substances (PS). Hospital staff also found five packages containing drugs hidden in Mr Clerkson's rectum but the pathologist was satisfied that these did not contribute to Mr Clerkson's death.

Findings

10. Mr Clerkson smuggled drugs into the prison with apparent ease. However, we are aware that since then, Durham has made good progress in tackling drug supply and now has a body scanner, which should make it far harder for prisoners to smuggle drugs through reception as Mr Clerkson did.

11. After Mr Clerkson's death, a prisoner told an officer that he had been offered drugs by Mr Clerkson in reception. The officer recorded his interview with the prisoner on his body-worn video camera (BWVC) and submitted an intelligence report. Although the report was seen by security staff, the BWVC footage was lost and never viewed by the security department. The prison should ensure that intelligence on drug use and the smuggling of drugs is properly recorded, shared and analysed.
12. During his induction to Durham, Mr Clerkson saw a Prisoner Information Desk (PID) worker (an experienced prisoner who provides information about services at Durham) who completed a Drug and Alcohol Recovery Team (DART) induction form. We consider that prisoners should not be tasked with assessing new prisoners' drug use and determining whether these prisoners should be referred to DART. This should be the responsibility of a member of prison or healthcare staff.
13. The clinical reviewer found that the resuscitation response was not in line with guidance and that this aspect of Mr Clerkson's care was not equivalent to that which he could have expected to receive in the community. We understand that disciplinary action has been taken against the two nurses involved.
14. We found that the care team was not notified of staff's attempts to resuscitate Mr Clerkson, which meant that support was not offered to the staff involved.

Recommendations

- The Governor and Head of Security should ensure that intelligence about illicit drug use and drug smuggling is properly recorded, shared and evaluated.
- The Governor and Head of Healthcare should ensure that initial DART assessments and referrals are completed by an appropriate member of staff.
- The Governor should ensure that the care team are notified after a resuscitation attempt of a prisoner so that staff are offered appropriate support, in line with national instructions.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Durham informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
16. The investigator obtained copies of relevant extracts from Mr Clerkson's prison and medical records.
17. The investigator interviewed eight members of staff at HMP Durham on 18 September 2018. She also contacted Mr Clerkson's cellmate to ask him about the events when Mr Clerkson became unwell but he did not respond.
18. NHS England commissioned an independent clinical reviewer to review Mr Clerkson's clinical care at the prison. They both conducted joint interviews at HMP Durham.
19. We informed HM Coroner for Darlington and Durham of the investigation. We suspended our investigation from 30 August 2018 to 16 May 2019 pending the results of Mr Clerkson's post-mortem examination. We have sent the Coroner a copy of this report.
20. The investigator contacted Mr Clerkson's next of kin to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond. Mr Clerkson's next of kin received a copy of the initial report. They did not raise any issues, or comment on the factual accuracy of the report.
21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Durham

22. HMP Durham, which holds up to 1,000 men, is a reception prison serving the courts of Durham, Tyneside and Cumbria. G4S provides primary healthcare services and Tees, Esk and Wear Valley NHS Trust provides mental health services. CGL provide psychosocial drug and alcohol services and Spectrum Community Healthcare provide GP Services.

HM Inspectorate of Prisons

23. The most recent full inspection of HMP Durham was in September and October 2018. Inspectors were concerned at the prevalence of illicit drugs. Nearly two-thirds of prisoners said that it was easy to get drugs and 30% said they had developed a drug habit since arriving at Durham. The average positive mandatory drug testing rate was high at around 30%.
24. Inspectors found it extremely worrying that there had been five suspected drug-related deaths in the previous eight months. Inspectors said the prison was aware of the dangers posed by drugs and had developed a strategy to address the problem, but the action taken was seriously undermined by the lack of up-to-date drug detection equipment.
25. HMIP carried out an Independent Review of Progress in July 2019. Inspectors reported that good progress had been made in stemming the supply of drugs. A body scanner was proving effective in deterring drug supply and finding illicit items. Many other steps had been taken or were in progress to reduce the supply of drugs, which was promising.

Independent Monitoring Board

26. 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 31 October 2018, the IMB reported that there were long waits in the holding cells in reception. The Board also said the prison should be provided with better technology to help tackle drugs. DART carried out excellent rehabilitative work.

Previous deaths at HMP Durham

27. Mr Clerkson was the 18th prisoner to die at Durham since August 2016. In 2018, there were five drug-related deaths. This is the second case we have investigated of drugs being smuggled in through reception. We have made previous recommendations about the need for effective measures to reduce the supply of and demand for drugs.

Psychoactive substances (PS)

28. PS (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in many ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the

influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

29. In July 2015, we published a Learning Lessons Bulletin about the use of PS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS, the need for more effective drug supply reduction strategies, better monitoring by drug treatment services and effective violence reduction strategies.
30. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drugs testing arrangements.

Body-worn video cameras

31. Body-worn video cameras (BWVCs) have been in use in public sector and contracted (private) prisons for a number of years. When used effectively, a BWVC allows visual and audio images to be captured to provide a clear record of events to protect both staff and prisoners. BWVCs must only be used for overt recording. Prison Service Instruction (PSI) 04/2017 gives instruction on the use of BWVCs in public sector prisons.

Key Events

32. On 3 August 2018, Mr Liam Clerkson was sentenced to six months in prison, charged with possession of an offensive weapon. He was sent to HMP Durham. Mr Clerkson had many previous convictions for which he had served time in prison.
33. Mr Clerkson arrived at Durham at approximately 6.00pm. An OASys assessor explained the reception process to the investigator. She said that new arrivals were searched when they came off the prison van, an officer spoke to them to confirm their personal details and they were then placed in a holding room. This would be followed by a strip search and then the offer of a meal. The prisoner would then be returned to the holding room to wait to see the healthcare staff, and after that they would be taken to their cell.
34. Mr Clerkson's cellmate told police that he had seen Mr Clerkson in the holding room acting under the influence and banging on the windows. He also said that he saw Mr Clerkson remove a Kinder egg from his trousers and hand out and take tablets from the egg.
35. An officer said that he saw Mr Clerkson in reception and he was agitated. He said that he was desperate to get onto A Wing. Staff told him that he would not be going to A Wing, but to E Wing. The officer said that when Mr Clerkson was in the holding room waiting to see a nurse, he was saying loudly that when he arrived on A Wing, nobody would be allowed to smoke PS (psychoactive substances).
36. A mental health nurse and a healthcare support worker completed Mr Clerkson's initial health screen at approximately 7.20pm. The mental health nurse completed drug tests on Mr Clerkson and the results were positive for benzodiazepine (a tranquiliser), cocaine and cannabinoids. He noted that Mr Clerkson was pacing back and forth, unable to sit still. Mr Clerkson told the nurse that he had a problem with alcohol and drugs. The nurse noted he seemed elated in mood and due to his drug misuse history, referred him to the mental health team. He also added Mr Clerkson to the 'overnight check list'. (Prisoners are added to the list when the reception nurse or GP identifies that they should be checked overnight, usually because of substance misuse issues. The senior nurse on duty carries out the checks 2-3 times during the night.)
37. As part of the induction process, newly arrived prisoners see a Prisoner Information Desk (PID) worker on their first night in custody. PID workers are experienced prisoners who provide information and advice about services at Durham. The PID worker also completes a Drug and Alcohol Recovery Team (DART) induction form. This includes an explanation of DART services and support available, as well as the provision of harm reduction and overdose risk information. There is a tick box with options for if a prisoner wants to engage with DART, and a third option for where there is no need for substance misuse treatment. Once completed, PID workers pass the forms to a member of staff in the DART team to process. The PID worker who completed Mr Clerkson's DART induction form ticked the box, to say that he would like to engage with the service.

38. A prison GP reviewed Mr Clarkson's record without meeting him (as it was late in the evening) and noted that in the light of the positive drug tests, she would refer him to the detoxification clinic.
39. The OASys assessor said she completed Mr Clarkson's basic custody screening (which is completed to identify a prisoner's needs while in custody) the morning after his arrival from information in his prison record. She noted that Mr Clarkson had been homeless and unemployed, and incorrectly noted that he did not have any alcohol or drug problems or had any contact with any alcohol or drug agency but had had previous contact with mental health services.

Events after Mr Clarkson was taken to his cell on Friday 3 August 2018

40. Prison staff allocated Mr Clarkson to a double cell on the first night centre (E Wing) for new arrivals. CCTV footage shows Mr Clarkson going into the cell at 9.19pm. His cellmate entered the cell at 9.34pm. Mr Clarkson's cellmate told police that Mr Clarkson was uncommunicative and "being like a zombie". He said that he saw foil inserted into the electrical points, possibly to ignite drugs, but he was not certain.
41. An officer completed the roll check at approximately 10.00pm. She said that she opened the observation flap and noticed Mr Clarkson's cellmate was standing up, looking over the privacy screen around the toilet, and she noticed two feet sticking out. Mr Clarkson's cellmate appeared to be worried and was calling Mr Clarkson but getting no response. The officer asked Mr Clarkson's cellmate if Mr Clarkson was alright and he said, "I don't know Miss", and looked panicked. She shouted down to a colleague that she needed assistance to enter the cell as a prisoner was unresponsive. When two officers arrived, an officer was the first to enter the cell. Mr Clarkson was slumped around the side of the toilet and she said he looked "quite blue". She radioed a medical emergency code blue (to indicate breathing difficulties). The control room called an ambulance immediately.
42. Two nurses heard the radio call and immediately made their way to the cell. A nurse said she collected the medical emergency bag. When she arrived at the cell there were several officers and a third nurse present. Body-worn video camera (BWVC) footage shows someone throwing water in Mr Clarkson's face as he was slumped unresponsive. This was subsequently identified as being the third nurse.
43. Two officers arrived at the cell. A nurse said they needed more space so both officers dragged Mr Clarkson out of the cell and his head hit the floor.
44. The nurse said she put an oxygen mask on Mr Clarkson's face and attached the defibrillator pads to his chest. The defibrillator said that there was no shockable rhythm. She used the pulse oximeter to check his pulse and oxygen levels but there was no reading. She began cardiopulmonary resuscitation (CPR) with assistance from the prison officers and the third nurse.
45. The nurse said she had problems as she attempted to insert an airway into Mr Clarkson's throat. On the BWVC footage she said that his tongue was swollen. CPR was stopped to clear vomit from Mr Clarkson's mouth. The nurse used the

suction machine and the BWVC footage showed that she was having difficulty using the equipment to inflate Mr Clerkson's lungs.

46. Staff continued with CPR and paramedics arrived on scene at 10.14pm. Paramedics continued emergency treatment from the wing to the ambulance and to hospital. Two prison officers escorted him and he was not restrained.
47. In hospital Mr Clerkson had an X-ray and unidentified items were found in his rectum. Hospital doctors recovered one Kinder egg and four cling film packages. Hospital staff notified the police when the drugs were found inside Mr Clerkson's body.
48. An officer found a bag with 'spice' (a type of PS), another bag with tobacco, a spoon and a cup with deodorant (used to smoke drugs) and a brown liquid in Mr Clerkson's cell. The officer said he passed the items to the duty manager for her to pass to the security department and he completed an intelligence report.
49. The officer also said that the day after Mr Clerkson collapsed, he recorded an interview using his BWVC with a new prisoner who said that Mr Clerkson had been saying in reception that he could supply drugs. The officer submitted an intelligence report.
50. Healthcare staff completed a serious incident report within 24 hours of Mr Clerkson's death. This summarised the events on 3 August and did not note any concerns. The report was copied to senior G4S and NHS England managers.

Contact with Mr Clerkson's family

51. In the early hours of 4 August, the prison appointed a member of the chaplaincy team as the family liaison officer (FLO). Mr Clerkson had nominated a next of kin. The FLO and an officer visited the address and found that they were not resident there, but a family member was and said that he would be the next of kin. The FLO told him that Mr Clerkson was seriously ill in hospital. Mr Clerkson's family member said Mr Clerkson's first next of kin should also be informed and supplied her address. The FLO and officer visited the address but no one was there. The FLO arranged for a taxi to take Mr Clerkson's family members to the hospital and offered support.
52. A prison manager contacted staff at HMP Northumberland as one of Mr Clerkson's relative was resident there. Staff arranged for a member of the chaplaincy team to tell him that Mr Clerkson was seriously ill in hospital. Prison staff arranged for him to visit him from HMP Northumberland.
53. When Mr Clerkson died, the FLO offered his condolences and support. Durham paid for Mr Clerkson's funeral, which was held on 31 August 2018.

Support for prisoners and staff

54. After Mr Clerkson collapsed in his cell, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. At interview, the OASys assessor, said that either the Duty Governor or the Night Orderly Officer should

have notified the care team so they could offer support to staff involved in the resuscitation attempt. She said it was not clear why this did not happen.

55. Staff moved Mr Clerkson's cellmate to another cell and offered him support. When Mr Clerkson died, the prison posted notices informing other prisoners of Mr Clerkson's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Clerkson's death.

Post-mortem report

56. The post-mortem examination found that Mr Clerkson's cause of death was hypoxic brain injury due to cardiorespiratory arrest, which had been caused by PS use.
57. Toxicology tests showed the presence of diazepam (a tranquiliser). The concentration was higher than therapeutic level but lower than the level associated with a fatal overdose. Toxicology results also found that Mr Clerkson had taken pregabalin (a pain killer which may be abused because of its euphoric effects). This was broadly at therapeutic level. It is not clear if he had been prescribed it.
58. The pathologist noted that Mr Clerkson had four intact cling film packages and a plastic container (from a Kinder egg) removed from his rectum. Tests on the packages showed that three of the cling film packages contained PS. The fourth contained temazepam tablets (sleeping pills) and three tablets which tested negative for drugs. The plastic container had buprenorphine (a heroin substitute) and diazepam tablets in it. The pathologist found that the packages did not contribute to Mr Clerkson's death.
59. The pathologist noted that concerns had been raised about the events when Mr Clerkson was found collapsed. She said there was no evidence of bruising to the head and therefore the banging of his head on the floor had not caused a significant injury. She noted that resuscitation was not started immediately and that for cardiac arrests, time is of the essence as the sooner the heart is restarted the greater chance of recovery. She said it appeared Mr Clerkson was not immediately assessed and removed from his cell, and resuscitation including potential clearing of his airway and commencement of chest compressions took several minutes. She concluded that it was difficult to know the precise impact of the delay because it was not known at what time Mr Clerkson's heart stopped.

Findings

Drug strategy at HMP Durham

60. Mr Clarkson died from the effects of PS, which he took shortly after arriving at Durham. In addition, several packages containing drugs were found secreted inside his body after his death. He was able to smuggle these drugs into the prison with apparent ease.
61. The HMIP inspection in September and October 2018, shortly after Mr Clarkson's death, found that drugs were easily available at Durham. Staff were aware of the problem and had a strategy to tackle it, but their efforts were severely hampered by the lack of up-to-date drug detection equipment.
62. HMIP's Independent Review of Progress conducted in July 2019 found that good progress had been made in stemming the supply of drugs. The prison now had a body scanner, which had proved effective in deterring the supply of drugs and in finding illicit items. It should now be much harder for prisoners to smuggle drugs into Durham through reception, in the way Mr Clarkson did.
63. Given the progress that Durham has made in tackling drug supply since Mr Clarkson's death, we make no recommendation.

Intelligence on drug supply

64. To try to minimise the flow of drugs into prisons, there needs to be an efficient system for recording and evaluating intelligence.
65. An officer submitted an intelligence report outlining his conversation with a prisoner who said that Mr Clarkson had offered him drugs in reception. The officer had also noted that he had recorded the conversation on his BWVC. The contents of the report were noted but regrettably the BWVC footage was not retrieved or saved. This information supported Mr Clarkson's cellmate's account of the events in the reception area. There is no record of prison staff noting any information from his cellmate or making a connection between the two separate pieces of information.
66. We are also concerned that, despite a prisoner being in the cell when Mr Clarkson collapsed, no one at Durham had spoken to him about the possibility that he may have seen the drugs Mr Clarkson had used. We make the following recommendation:

The Governor and Head of Security should ensure that intelligence about illicit drug use and drug smuggling is properly recorded, shared and evaluated.

First night drugs questionnaire

67. We appreciate that PIDs workers (who are trusted prisoners) can play an important role in welcoming new arrivals, giving them information and helping them settle into prison. However, information about new, and potentially vulnerable, prisoners' drug use and treatment needs should be confidential. It should be the responsibility of prison or healthcare staff to ensure that new

prisoners are properly assessed and to make appropriate referrals. In their most recent inspection, HM Inspectorate of Prisons also found that PIDs workers undertook some tasks that should have been the responsibility of prison staff.

68. We note that this is the second investigation into a death at Durham in which we have expressed concern about prisoners completing DART referrals. The first death occurred in May 2018. We repeat the following recommendation:

The Governor and Head of Healthcare should ensure that initial DART assessments and referrals are completed by an appropriate member of staff.

Emergency response

69. When an officer realised that something was wrong with Mr Clarkson at the 10.00pm roll check, she responded promptly and appropriately. She immediately called for assistance and prison staff quickly entered the cell to try to assist him. When the officer realised that Mr Clarkson was unresponsive, she immediately called a medical emergency code blue. Nurses responded and arrived quickly.
70. The BWVC footage gives a clear account of the events during the medical emergency. Following examination of this footage, the clinical reviewer found that the resuscitation was not delivered in line with Resuscitation Council Guidelines. Mr Clarkson was not immediately assessed and removed from his cell; there was an interruption in chest compressions; and the suction machine was not collected and brought to the cell. We were also concerned to see a nurse throwing water in Mr Clarkson's face, which is not accepted practice.
71. The clinical reviewer found that the emergency care Mr Clarkson received was not equivalent to that which he could have expected to receive in the community. The clinical reviewer has also made recommendations which have not been repeated in this report but the Head of Healthcare will need to address.
72. Given the very serious concerns raised about the nurses involved in the emergency response, we drew the BWVC footage to the attention of NHS England and G4S managers. The Head of Commissioning, Health and Justice at NHS England wrote to the National Director of Healthcare Secure for G4S on 14 February 2019 and asked for a formal response about a number of aspects of Mr Clarkson's care when he collapsed. These included:
- The opening of the healthcare report completed 24 hours after Mr Clarkson's death (which should also include plans for not just Durham but all North-East prisons).
 - Confirmation of when the BWVC footage had been viewed by G4S (including when the Head of Healthcare had access to the footage), actions taken by senior managers at Durham and the Regional Team.
 - Communication plans with the Governor of HMP Durham.
73. On 15 February, the Medical Director at G4S, said she would chair a specially convened G4S SI panel to investigate the concerns. The investigator asked for a copy of the investigation. Although a copy of the investigation was never

provided, the Associate Director – Cumbria and North East and clinical governance lead at G4S, said that when the BWVC footage was viewed the two nurses were immediately suspended. She said that a formal investigation process was launched and led by the G4S, Clinical Governance Manager. Disciplinary action was subsequently taken against the two nurses. We therefore make no recommendation.

Staff support

74. Prison Service Instruction (PSI) 64/2011 requires that where staff are affected by events leading to a death they should be identified and offered support. This means that the staff involved in the resuscitation attempt should have been offered support. However, the OASys assessor, said that there had been a breakdown in the care team being notified when Mr Clerkson collapsed in the cell and staff attempted resuscitation.

75. We therefore recommend:

The Governor should ensure that the care team are notified after a resuscitation attempt of a prisoner so that staff are offered appropriate support, in line with national instructions.

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