Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Esha Dillon a prisoner at HMP Stocken on 24 March 2018

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.

Mr Esha Dillon died on 24 March 2018 while a prisoner at HMP Stocken. The cause of his death was unascertained. He was 22 years old. I offer my condolences to his family and friends.

The toxicology report noted that Mr Dillon had a prescription-only drug, which had not been prescribed to him, in his system when he died and that this might have contributed to his death. I am concerned that Stocken's local substance misuse strategy did not address the trading of prescribed medication.

It is also possible that Mr Dillon's death may have been caused by a psychoactive substance (PS) which was not identified in the toxicology tests.

I am very concerned that the officer who responded, who did not radio a medical emergency code, was told not to open the cell door to attend to him until a custodial manager arrived. This resulted in a delay of eight minutes before Mr Dillon's cell door was opened and an ambulance was called. During this time, Mr Dillon stopped breathing and lost consciousness. He was pronounced dead 90 minutes later.

I am also concerned that this is the second time within a short period that I have identified a failure at Stocken to go into a cell promptly during an emergency and to radio an emergency code.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **December 2018**

Contents

Summary

Events

1. On 3 March 2017, Mr Esha Dillon was remanded to HMP Woodhill. On 24 March, he was sentenced to three years and four months in prison for supplying drugs. On 11 April, he was transferred to HMP Stocken.

2. Mr Dillon had long-term health issues, including asthma (a condition that causes inflammation of the lungs, resulting in shortness of breath and breathing difficulties), eczema (inflammation of the skin) and food allergies.

3. A prison GP prescribed two types of inhalers.

4. On 2 August, a nurse saw Mr Dillon for an asthma review. He told the nurse that he had only been using one of his inhalers. The nurse noted that Mr Dillon's technique for using the inhalers was poor.

5. Mr Dillon did not attend four asthma reviews at the end of 2017 and the beginning of 2018. He overused his inhaler and occasionally used his brother's inhaler. (His brother lived on the same wing.)

6. On 22 March, a nurse saw Mr Dillon for an asthma review. He told her that he was frequently short of breath, that he woke with symptoms of asthma two to four times a week and had regular symptoms of asthma during the day. The nurse noted that he had a 'terrible' inhaler technique.

7. At 5.32pm on 24 March, Mr Dillon pressed his cell bell. An officer responded promptly and saw Mr Dillon sitting on his bed, gasping for air and struggling to breathe. He called for assistance but did not radio a code blue (which indicates that a prisoner is unconscious or not breathing). Mr Dillon slid off the bed onto the floor. The officer then radioed a custodial manager to ask for permission to go into the cell but the custodial manager told him to wait until he arrived.

8. At 5.40pm, the custodial manager arrived at Mr Dillon's cell with two officers and opened the door. Mr Dillon was unconscious and not breathing. An officer radioed a code blue and an ambulance was called immediately.

9. The officers started cardiopulmonary resuscitation (CPR) and used a defibrillator. They continued CPR until paramedics arrived. Around 6.00pm, two ambulances arrived at the prison. The paramedics took over CPR and treatment. At 7.09pm, an emergency doctor pronounced that Mr Dillon had died.

10. After Mr Dillon died, the custodial manager and the Governor went to Mr Dillon's brother's cell and told him that Mr Dillon had died. They offered their condolences. Mr Dillon's brother was very upset, and they took him to his friend's cell for comfort and support.

11. At 8.20pm, the Head of Offender Management in Custody asked the police to tell Mr Dillon's mother that he had died. Police officers visited her and broke the news to his family. A police officer said that the family asked them to leave.

12. Tablets found in Mr Dillon's cell and a tablet which Mr Dillon allegedly gave to another prisoner were found to be propranolol (a beta-blocker). The toxicology report noted that Mr Dillon had propranolol and naloxone in his system. Propranolol is a prescription-only drug which was not prescribed to him. Naloxone blocks the effects of an opioid drug and may be used by a paramedic during a cardiac arrest. After his death, an intelligence report noted that Mr Dillon had used a drug newly available on his wing.

13. A post-mortem examination found that the cause of Mr Dillon's death was unascertained, although it did not rule out the possibility that Mr Dillon might have died as a result of taking either propranolol or an unknown substance such as a psychoactive substance (PS) which is difficult to detect in toxicology tests.

Findings

Clinical care

14. The clinical reviewer concluded that the care that Mr Dillon received at Stocken was equivalent to that which he could have expected to receive in the community. Mr Dillon received good care for his asthma and eczema.

Substance misuse

15. In light of the findings of the post-mortem report, we cannot say whether Mr Dillon died from the effects of an unknown substance or whether the propranolol he took adversely affected him because of his asthma. It is clear, though, from the toxicology results that he misused propranolol and might also have taken another substance.

16. The availability and misuse of illicit substances is a problem across the whole prison estate. Stocken's drug strategy does not currently address the trading of prescription medication which we consider was an issue in this case.

Emergency response

17. The officer who responded to Mr Dillon and found him struggling to breathe did not radio a medical emergency code blue, as he should have done. The officer should have gone into Mr Dillon's cell as it was a medical emergency but the custodial manager he called instructed him not to do so but to wait for him to arrive. As a direct consequence there was an eight-minute delay before the cell door was opened and an ambulance called. We cannot now know whether an earlier response might have saved Mr Dillon's life but we note that during that time he lost consciousness and stopped breathing.

Contact with Mr Dillon's family

18. We are satisfied that prison staff offered appropriate support to Mr Dillon's brother and appropriately arranged for the police as a matter of urgency to tell Mr Dillon's family that he had died.

Recommendations

- The Governor and Head of Healthcare should ensure that their substance misuse strategy addresses the trading of prescribed medication and that effective steps are taken to prevent it.

- The Governor should ensure that staff are given clear guidance and understand the circumstances in which they should radio a medical emergency code and go into a cell during patrol or night state.

The Investigation Process

19. The investigator issued notices to staff and prisoners at HMP Stocken informing them of the investigation and asking for anyone with relevant information to contact him. Two prisoners contacted him.

20. The investigator visited Stocken on 9 April. He obtained copies of relevant extracts from Mr Dillon's prison and medical records.

21. The investigator interviewed seven members of staff and three prisoners at Stocken between 9 April and 31 May.

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

23. We informed HM Coroner for Rutland and North Leicestershire of the investigation who gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

24. One of the Ombudsman's family liaison officers contacted Mr Dillon's mother to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She had the following concerns:

    - Mr Dillon had severe chronic asthma. She understood that he had been given some inhalers but these were shared with his brother who had the same condition. She understood that when Mr Dillon asked for extra inhalers, they were declined. She wanted to know why.

    - She asked what provisions were in place for Mr Dillon to have had access to a nebuliser and how it would be administered. She said that if Mr Dillon had a serious asthma attack, his inhalers would not have worked.

    - She said that Mr Dillon's brother was aware that he had been struggling for five days with his asthma. She asked what the prison did to assist him with his symptoms during this five-day period. (It is not clear what five-day period she was referring to.)

    - She said that his brother was given Mr Dillon's medication (a batch of inhalers) the day after he died. She said that this was insensitive and upsetting for his brother. She asked whether there had been a delay in Mr Dillon getting his inhalers.

    - She said that the police came to her home at 9.40pm to tell her that Mr Dillon had died. She said that she was unhappy that they had told her that Mr Dillon had died of a drug overdose.

25. We shared the initial report with the Prison Service. There were no reported factual inaccuracies. Their action plan has been appended to this report.

26. Mr Dillon's mother received a copy of the initial report. The solicitor representing Mr Dillon's mother wrote to us raising a number of questions. We have provided

clarification by way of separate correspondence to the solicitor. There was one reported factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Stocken

27. HMP Stocken is a medium security prison in Rutland which holds up to 842 men. Healthcare is provided by Care UK, and mental health services are sub-contracted to Northamptonshire Foundation NHS Trust. The service operates from Monday to Friday from 7.30am to 6.30pm and from 8.00am to 5.30pm at weekends. Two GPs provide ten GP sessions per week.

HM Inspectorate of Prisons

28. The most recent inspection of HMP Stocken was conducted in July 2015. Inspectors reported that health services were good, particularly in identifying and supporting prisoners with complex health needs. Waiting times for GP, nurse and dental service appointments were acceptable but prisoners waited too long for most other health services.

Independent Monitoring Board

29. 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 April 2017, the IMB reported that Care UK had recently taken over the contract for healthcare services. Waiting lists for dental and optician treatment had reduced although the number of prisoners who did not attend appointments remained too high. They noted that Stocken was addressing the number of hospital appointments cancelled due to a lack of escorts.

Previous deaths at HMP Stocken

30. Mr Dillon was the seventh prisoner to die at Stocken since March 2015. Five of these deaths were from natural causes and one was self-inflicted. In an investigation report we issued in July 2018, we identified deficiencies in the emergency response: the failure to go into a cell promptly and the failure to use an emergency code.

Psychoactive Substances (PS)

31. Psychoactive substances (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 a number of 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.

32. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) 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.

33. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Key Events

34. On 3 March 2017, Mr Esha Dillon was remanded to HMP Woodhill. On 24 March, he was sentenced to three years and four months in prison for supplying drugs. On 11 April, he was transferred to HMP Stocken.

Clinical care

35. At his initial health screen that day, a nurse noted that Mr Dillon had long-term health issues, including asthma, eczema and food allergies. Mr Dillon told the nurse that he regularly used cannabis, smoked and drank alcohol moderately.

36. A prison GP prescribed salbutamol (a medication that opens up the airways to the lungs) and beclomethasone dipropionate (a steroid medication which reduces inflammation and secretions in the lungs) inhalers for asthma. He was also prescribed medication for eczema. Mr Dillon had previously been prescribed an EpiPen (an automatic injection device containing adrenaline) but not at Stocken.

37. The Head of Healthcare said that nebulisers (a compressor used to turn liquid medication into a fine mist) are not routinely used for asthmatic patients and are only recommended for those whose asthma is not well controlled with combination inhalers and are under the care of a hospital.

38. On 2 August, a nurse saw Mr Dillon for an asthma review. He told her that he was only using the salbutamol inhaler and not the beclomethasone dipropionate inhaler. (The combination of both types of inhaler is a preferred treatment which aims to lower the number and intensity of asthma attacks.)

39. The nurse noted that Mr Dillon had a poor technique for using inhalers. He told her that his asthma restricted his exercise, that he often woke at night with breathing difficulties and that he had asthma symptoms daily. She noted that Mr Dillon's peak expiratory flow rate (the volume of air breathed out) was 400 litres per minute. Normal rates are between 400 and 700 litres per minute.

40. The nurse referred Mr Dillon to a prison GP to prescribe a beclomethasone dipropionate inhaler. She planned to teach Mr Dillon how to use his inhaler properly, encourage him to attend a smoking cessation group and to review him in six to eight weeks.

41. Mr Dillon's medical record showed that he was overusing his salbutamol inhaler and that he sometimes used his brother's. (His brother lived on the same wing.) He was issued with eight inhalers between September 2017 and March 2018. An inhaler should last at least one month if used daily at the prescribed rate. There is no evidence that staff declined to prescribe Mr Dillon inhalers.

42. An officer who worked on Mr Dillon's wing, said that he knew Mr Dillon was asthmatic because after he was locked in his cell, he sometimes told him that he had to get his inhaler from his brother's cell. He said that the brothers would sometimes swap inhalers.

43. Mr Dillon did not attend routine asthma reviews in September or December 2017, January or March 2018. On 21 March, Mr Dillon asked a nurse for a salbutamol inhaler. She asked him to come back for an asthma review the next day.

44. On 22 March, the nurse saw Mr Dillon for his asthma review. She noted that he was overusing the salbutamol inhaler and had stopped using the beclomethasone dipropionate inhaler in November 2017. Mr Dillon told her that he was frequently short of breath, that he woke up with symptoms of asthma two to four times a week and had regular symptoms of asthma during the day. Mr Dillon told her that he used three puffs of the salbutamol inhaler, three times a day. She noted that his inhaler technique was terrible and told him to use two puffs, four times a day. She noted that he might improve with a better inhaler technique and by using the beclomethasone dipropionate inhaler which she re-prescribed. She planned to review Mr Dillon after 12 weeks.

45. A prisoner said that a month and a half before Mr Dillon died, they were both in the healthcare department. He said that Mr Dillon begged the officers for help because he could not breathe and asked for an emergency appointment. He said that the officers told him that they could not arrange one. The prisoner said that Mr Dillon came to his cell three days before he died and felt very bad. He said that he wanted some paracetamol.

46. Another prisoner said that he had been Mr Dillon's friend. He said that he knew Mr Dillon had asthma and would get quite wheezy. He said that he saw Mr Dillon in the healthcare department before he died. He said that Mr Dillon was agitated because he told staff that his asthma inhaler had run out but that staff would not let him have another one.

Emergency response

47. At 5.32pm on 24 March, Mr Dillon pressed his cell bell. Officer A promptly answered the call and found Mr Dillon sitting on his bed, gasping for air. He said that Mr Dillon told him that he was struggling to breathe. He said that Mr Dillon was trying to find his inhaler in a cupboard behind a curtain beside the bed. He told him to open the vent on his cell window to get some air. He said that about five minutes later, Mr Dillon started having seizures, was shaking and had a very worried look on his face. He called for assistance but did not call a code blue emergency. Mr Dillon then slid off the bed onto the floor.

48. Officer A radioed the custodial manager (CM) for permission to go into the cell but the CM told him not to do so and to wait for other staff to arrive. He said that Mr Dillon may have moved slightly during this time.

49. The CM said that he was the night orderly officer at the time of the incident and was assisted by four officers to deal with incidents throughout the prison. He said that when officer A radioed to say that Mr Dillon required help, he was in the centre office about 600 or 700 metres from Mr Dillon's cell. Two minutes later, officer A radioed again and said that Mr Dillon had collapsed. He said that he arrived about six minutes later.

50. The CM said that the incident happened during patrol state when prisoners are locked in their cells and the staff level is reduced to one officer on each residential unit. He said that no cells can be opened unless there is a minimum of three members of staff present.

51. The CM said that if officers believed that there was an extreme medical emergency, they could enter a cell without waiting for more staff to arrive to preserve life. The officer would radio the relevant emergency code. He said that examples of a medical emergency included a heart attack or if a prisoner tried to self-harm.

52. At 5.40pm, the CM arrived at Mr Dillon's cell with Officer B and Officer C. Officer A immediately opened the door. They placed Mr Dillon on the bed. The CM and Officer B looked for a pulse and saw that Mr Dillon was unconscious and not breathing. Officer C radioed a code blue and the communications officer immediately called an ambulance.

53. The CM and Officer B started cardiopulmonary resuscitation (CPR). Officer B tilted Mr Dillon's head back to clear his airway and the CM started chest compressions. Officer A went to the wing office to get the defibrillator and the CM attached it to Mr Dillon's chest. The defibrillator advised not to shock Mr Dillon but to continue CPR. Officer D, Officer E and Officer A completed chest compressions, and continued CPR until the paramedics arrived.

54. The CM said that the space in the cell was tight but they did not think to move him. He said that they had enough space to do CPR. At 6.00pm, an ambulance arrived at the prison, followed four minutes later by another ambulance and officers escorted the paramedics promptly to the cell. When the paramedics arrived, they moved Mr Dillon to the landing to give them more room. The paramedics took over CPR and treatment.

55. The CM said that the prisoners on the wing were very noisy when they were doing CPR because they were trying to tell Mr Dillon's brother who was in a cell on the landing below what was going on.

56. Officer A went to Mr Dillon's brother's cell and told him that the paramedics were working on his brother and reassured him that they were doing all that they could.

57. At 6.15pm, an emergency doctor arrived at the prison. At 7.09pm, the emergency doctor pronounced that Mr Dillon had died. Officers moved Mr Dillon's body to the healthcare department.

58. Officer F went to the wing to help with the emergency response. When she was on the wing, a prisoner told her that Mr Dillon may have taken propranolol, a prescribed drug. Officer F told the doctor and the paramedics that he may have taken the drug.

59. Officer E said that after Mr Dillon died, a prisoner pressed his cell bell. The prisoner told Officer E that Mr Dillon earlier gave him a pill which was identified as propranolol. The post-mortem report noted that tablets were found in Mr Dillon's cell after he died which the police also identified as propranolol. Mr Dillon was not prescribed propranolol tablets.

Other information about Mr Dillon's death

60. On 28 March, a prison intelligence report noted that there was a drug newly available on Mr Dillon's wing which was described as "very nasty". The report

noted that he had “partied with the new stuff available”. The report noted that Mr Dillon had taken the drug before he died but is not specific about when.

61. The Head of Security said that there was very little intelligence information about Mr Dillon. There was intelligence to say his behaviour was poor, but there was no intelligence to link him to drug dealing on the wing.

Contact with Mr Dillon’s family

62. After Mr Dillon died, the CM, the Governor and the Head of Offender Management in Custody visited Mr Dillon’s brother in his cell. The Governor told Mr Dillon’s brother that he had died and offered his condolences. Because he was very upset, they took him to his friend’s cell for comfort and support.

63. At 8.20pm, the Head of Offender Management in Custody asked the police to inform Mr Dillon’s mother that he had died. He wanted her to be told as soon as possible so that Mr Dillon’s brother could then speak to his mother. Three police officers promptly visited her. Mr Dillon’s father and brothers were also present. A police officer said that his colleague told Mr Dillon’s mother that he had died and the family asked how he had died. He said that they told Mr Dillon’s mother that they did not know how he died but said that he might have died from taking drugs. After three minutes, the family asked them to leave.

64. The CM said that Mr Dillon’s brother later telephoned his mother from an office telephone.

65. The Head of Offender Management in Custody appointed two offender supervisors as the family liaison officers.

66. At 2.10pm on 25 March, Mr Dillon’s mother, father and four brothers went to Stocken. The CM told them what happened when Mr Dillon died. One of the prison family liaison officer told the family that she was the family liaison officer and offered her condolences.

67. On 28 March, Mr Dillon’s family went to Mr Dillon’s memorial service at Stocken. The prison family liaison officers remained in contact with Mr Dillon’s mother and family.

68. Mr Dillon’s funeral took place on 4 May, and Mr Dillon’s brother attended. The prison contributed to its cost in line with national instructions.

Support for prisoners and staff

69. After Mr Dillon’s death, the Governor debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

70. The prison posted notices informing other prisoners of Mr Dillon’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 Dillon’s death.

Post-mortem report

71. A post-mortem examination found that the cause of Mr Dillon's death remained unascertained. Toxicology tests detected a low level of propranolol (a beta-blocker which slows down the heart and which was not prescribed to Mr Dillon) salbutamol, nicotine, naloxone (which blocks the effects of an opioid and can be used by a paramedic during a cardiac arrest) and caffeine in Mr Dillon's bloodstream. A test for an allergic reaction was done which found no evidence of an anaphylactic reaction.

72. The post-mortem report noted that Mr Dillon had a diagnosis of asthma and that the use of propranolol was contra-indicated in asthmatic patients because it can make asthma worse and cause bronchospasm (a tightening of muscles in the lungs which results in narrowed airways. However, it also noted that Mr Dillon's lungs did not indicate changes to suggest he had had an acute asthma attack, and no other natural diseases were identified to account for his death.

73. The post-mortem report did not indicate the presence of any drugs, other than those listed above. However, it noted that toxicology tests do not detect all variations of synthetic cannabinoids (known as psychoactive substances or PS) and it was possible that such a substance might have caused Mr Dillon's death.

Findings

Clinical care

74. The clinical reviewer concluded that the care that Mr Dillon received at Stocken was equivalent to that which he could have expected to receive in the community. He noted that although Mr Dillon did not use his prescribed beclomethasone dipropionate inhaler, did not attend all his asthma reviews and had a poor inhaler technique, the healthcare that he received for asthma and eczema appear to have been delivered well and in line with national guidelines.

Substance misuse

75. Although there was no intelligence before Mr Dillon's death to link him to substance misuse or involvement in the prison's drug culture, there was clear evidence after his death that he had taken a prescription drug he was not prescribed.

76. The post-mortem report identified a low level of propranolol (which is contra-indicated for people with asthma) and naloxone (most likely used by the paramedics who treated Mr Dillon), neither of which were prescribed to him. Propranolol tablets were also found in his cell after his death and another prisoner had a propranolol tablet which he said Mr Dillon had given him. Although the post-mortem report found that Mr Dillon's cause of death was unascertained, it is possible that Mr Dillon's use propranalol may have played a part.

77. The post-mortem also noted the possibility that PS might have caused Mr Dillon's death as PS are poorly detected by toxicology tests.

78. The investigation found that the prison is currently taking a number of measures to tackle the problem of drug availability and misuse, including the use of search dogs, cell searches, processing mail and using fabric checks to look for illicit items in cells or suspicious behaviour of prisoners. The Head of Security said that the use of PS had increased at Stocken over the last six months and he had asked for more regional search dogs to address the issue.

79. We accept that Stocken has a drug strategy in place and staff are working hard to implement it. Nevertheless, more needs to be done to reduce both the supply and the demand for substances, including the trading of prescribed medication.

80. Stocken is not alone in facing this problem – it is a serious problem across much of the prison estate. However, in our view, there is now an urgent need for national guidance to prisons from HMPPS providing evidence-based advice on what works.

81. In a recent investigation, we recommended that the Chief Executive of HMPPS should issue detailed national guidance on measures to reduce the supply of and demand for drugs in prisons. The Chief Executive told us that HMPPS plan to issue a national drug strategy in the autumn of 2018.

82. Meanwhile, we are concerned that Stocken's drug strategy does not sufficiently address the trading of prescribed medication which was clearly an issue in this case. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that their substance misuse strategy addresses the trading of prescribed medication and that effective steps are taken to address it.

Emergency response

83. Prison Service Instruction (PSI) 03/2013 on medical emergency response codes requires that a code blue is called if a prisoner has breathing difficulties or is unconscious so that an ambulance is called immediately. When the officer answered Mr Dillon's cell bell and saw that he had breathing difficulties, he radioed for assistance and called the custodial manager but should also have called a medical emergency code blue. Not using a medical emergency code meant that an ambulance was not called immediately and staff were not sufficiently aware of the serious nature of the incident to enable them to respond appropriately.

84. PSI 24/2011 on management and security at nights requires that all prisoners are locked in their cells during night state. Under normal circumstances, the night orderly officer must give authority to unlock a cell during night state, and no cell should be opened unless at least two or three members of staff are present, one of whom should be the night orderly officer. However, the PSI states that the preservation of life must take precedence. It says that where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night orderly officer and an individual member of staff may go into the cell on their own. However, night staff should not take action that they feel would put themselves or others in unnecessary danger. The requirements for patrol state are the same as for night state, other than that staff have a cell key rather than a key in a sealed pouch.

85. The PSI states that before going into a cell, staff should make every effort to gain a verbal response from the prisoner. This, together with what the member of staff observes through the panel and any knowledge of the prisoner, should inform a rapid dynamic risk assessment of the situation and a decision about whether to enter immediately or wait for assistance.

86. In line with the PSI, Stocken's security strategy states that the preservation of life overrides security concerns in the case of a life-threatening emergency. It says that a member of staff may enter a cell with caution, ensuring their own safety under these circumstances.

87. On the evening that Mr Dillon died, the prison was in patrol state, and an officer was alone on the wing. He should have felt empowered to assess the risk of entering and decide whether to go in to the cell immediately or wait for assistance. It is clear that he wanted to go in because he asked for the custodial manager's permission.

88. In the circumstances, the officer should have gone into the cell and the custodial manager should have allowed him to do so because it was clear to the officer

that Mr Dillon's life was at risk. The officer said that he was just standing there outside the door looking at Mr Dillon and could not do anything. He said that he wanted to do something but because he was advised not to, he had to wait for staff to arrive.

89. There was a delay of eight minutes before the custodial manager and other staff arrived to open the cell door and call for an ambulance. We cannot now know whether an earlier response might have saved Mr Dillon's life. We make the following recommendation:

The Governor should ensure that staff are given clear guidance and understand the circumstances in which they should go into a cell during patrol state and radio a medical emergency code.

Contact with Mr Dillon's family

90. PSI 64/2011 on the management of prisoners at risk requires that, wherever possible, the family liaison officer and another member of staff must visit and inform the next of kin in person of the death. However, when the prison is a long way from the next of kin, then consideration must be given to requesting the assistance of a family liaison officer from the nearest prison.

91. Mr Dillon's mother lived in London, a long way from Stocken. The Head of Offender Management in Custody said that he considered asking for prison staff from a London prison to attend Mr Dillon's mother's home. However, because Mr Dillon's brother wanted to speak to his mother as soon as possible, he decided that police officers would be able to respond more urgently to break the news to Mr Dillon's mother.

92. We are satisfied that the Head of Offender Management in Custody request for the police to inform Mr Dillon's mother that he had died was appropriate given the circumstances because Mr Dillon's brother was able to promptly speak to his mother.

93. The order states that the prison must arrange a follow up visit as soon as possible. We are satisfied that prison staff did then speak to Mr Dillon's mother and because the family wanted to visit the prison arranged a face-to-face visit the following morning.

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Independent Investigations

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