

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Garratt a prisoner at HMP Hewell on 7 September 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*



© Crown copyright 2021

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 John Garratt died in hospital on 7 September 2018 of extensive burns and smoke inhalation, while a prisoner at HMP Hewell. He was 31 years old. I offer my condolences to Mr Garratt's family and friends.

Mr Garratt suffered serious burn injuries on 5 September, when he set himself alight while apparently smoking psychoactive substances (PS) in his cell. He received treatment in hospital but his injuries were not survivable.

Mr Garratt had a history of substance misuse. The investigation found that his clinical care was equivalent to that which he could have expected to receive in the community. He was offered support and advice with his substance misuse issues and staff responded appropriately on the occasions when Mr Garratt was found under the influence of PS.

I commend healthcare staff who managed his burn injuries well during a traumatic and distressing incident, and ensured he received the best possible care in very difficult circumstances.

I am, however, concerned that on 5 September, Mr Garratt's emergency cell bell was not answered for 16 minutes before he was discovered on fire in his cell. This caused an unnecessary delay in Mr Garratt receiving emergency medical treatment and may have affected the outcome for him.

I am also concerned that Mr Garratt was able to obtain PS within five days of arriving at Hewell. The prison has a well-articulated local drug strategy that it is working to implement, but I am concerned that individual prisons are being left to develop local strategies to reduce the supply and demand for drugs. This is a national problem which needs national solutions and an open acknowledgement of the resources required to address it effectively.

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

May 2019

Contents

Summary 1

The Investigation Process 4

Background Information 5

Key events..... 7

Findings..... 13

Summary

Events

1. Mr John Garratt was released from prison on licence on 23 June 2017, after serving a sentence for robbery. On 20 October, he was recalled to HMP Birmingham after poor behaviour in the community. On 10 January 2018, he was transferred to HMP Featherstone.
2. Mr Garratt had a long history of substance misuse and was frequently identified as being under the influence of psychoactive substances (PS) or other illicit drugs in prison. He received support from the mental health team and substance misuse services (SMS) at Featherstone, who offered support and advice with his continued drug problems, but he failed to engage and continued using illicit drugs.
3. His custodial behaviour was poor, which resulted in his transfer from HMP Featherstone to HMP Hewell on 31 August.
4. On the morning of 5 September, all prisoners were locked in their cells at Hewell while staff attended a full staff briefing. An officer volunteered to remain on Mr Garratt's house block, on his own, to supervise the house block, to monitor those prisoners on suicide and self-harm prevention procedures (known as ACCT), and to answer emergency cell bells.
5. At 12.30pm, Mr Garratt pressed his cell bell but the officer did not go to Mr Garratt's cell to see what he wanted.
6. At 12.40pm, another officer returned to the house block from the staff meeting and went to complete an ACCT observation. He noticed that Mr Garratt's cell bell was illuminated and went to answer it at about 12.46pm. As he got close to the cell, he could smell burning. When he reached the door, he realised that the observation panel was obscured by smoke and, when he called to Mr Garratt, Mr Garratt replied, "Help me, boss." The officer immediately used his radio to alert staff to a possible cell fire and requested assistance.
7. At 12.48pm staff began to mist water into Mr Garratt's cell via the inundation point in the door. At 12.59pm, staff entered the cell, and found Mr Garratt sitting on the lower bunk. His clothes were burnt off and he had severe burns to most of his body. He was conscious but appeared unable to comply with staff instructions. He was helped to an empty cell next door, where nursing staff treated him.
8. Ambulance staff arrived at 1.20pm and took over treatment. Mr Garratt was given fluids and pain relief before being taken to hospital.
9. Mr Garratt underwent several procedures in hospital, but his injuries were not survivable. On the morning of 7 September, treatment was withdrawn and at 12.05pm, it was confirmed that Mr Garratt had died.

Findings

10. It appears that Mr Garratt set himself on fire while smoking PS in his cell and may not have reacted initially because he was under the influence of the drug. There is no evidence that this was anything other than accidental.
11. We are satisfied that staff at Featherstone offered Mr Garratt support and advice with his substance misuse issues and had responded appropriately when he was found under the influence of PS. He had only been at HMP Hewell for five days and had not co-operated with attempts to complete his health screening.
12. We agree with the clinical reviewer that healthcare staff should be commended for the emergency care provided to Mr Garratt during a traumatic and distressing incident, ensuring that he received the best possible care in very difficult circumstances. We are satisfied that he received a standard of care equivalent to that which he could have expected to receive in the community.
13. However, the 16-minute delay in responding to Mr Garratt's cell bell before he was discovered with severe burns was unacceptable. Cell bells should be answered promptly, and HM Inspectorate of Prisons (HMIP) have an expectation, which we share, that they should be answered within five minutes (other than in exceptional circumstances). Although we recognise that the officer concerned was working on his own and had other tasks, a 16-minute delay was simply too long and he should not have muted the cell bell buzzer. If another member of staff had not noticed by chance that Mr Garratt's cell bell light was on, the delay in responding would have been even longer.
14. If staff had responded to Mr Garratt's cell bell promptly, his life might have been saved. The burns specialist who treated Mr Garratt said that in his opinion the delay 'definitely affected the outcome' for Mr Garratt.
15. The officer concerned also recorded that he had observed another prisoner who was subject to suicide and self-harm monitoring procedures at 12.35pm, when in fact he had not done so.
16. We are satisfied that staff responded quickly and professionally to the fire and began inundating Mr Garratt's cell very quickly.
17. The cell was inundated for 11 minutes before staff entered and tried to remove Mr Garratt. It is outside our area of expertise to say whether this was an excessive length of time.
18. We are concerned that no one called a medical emergency code (which would have triggered the control room to call an ambulance and healthcare staff to attend with the appropriate equipment). Although this probably made little practical difference in this case, it could be critical in future cases.
19. We are concerned about the easy availability of drugs at Hewell. It is particularly troubling that Mr Garratt was able to access drugs within five days of arriving at Hewell. Although the prison has a substance misuse strategy, more clearly needs to be done to reduce supply and demand.

Recommendations

- The Governor should commission an internal investigation into the actions of an officer on 5 September 2018, with a view to considering if disciplinary action is appropriate.
- The Governor should ensure that staff respond to all cell bells 'promptly', that is within five minutes (other than in exceptional circumstances).
- The Governor and Head of Healthcare should ensure that all staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that staff promptly use an emergency code to effectively communicate the nature of the emergency.
- The Chief Executive of HMPPS should provide the Ombudsman with a revised date for issuing detailed national guidance on measures to reduce the supply and demand of drugs in prisons, and an assurance that this new date will be met.

The Investigation Process

20. The investigator issued notices to staff and prisoners at HMP Hewell informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
21. The investigator obtained copies of relevant extracts from Mr Garratt's prison and medical records.
22. The investigator interviewed seven members of staff at Hewell between 5 November and 4 December 2018.
23. NHS England commissioned a clinical reviewer to review Mr Garratt's clinical care at the prison. The clinical reviewer attended interviews with the investigator.
24. We informed HM Coroner for Worcestershire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
25. The investigator wrote to Mr Garratt's family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Garratt's father said the family would like to receive a copy of our investigation report.

Background Information

HMP Hewell

26. HMP Hewell holds remand and sentenced adult male prisoners. House blocks 1-6 have a total operational capacity of 1,278. Care UK provides health services, including on-site paramedics, and there is an 18-bed inpatient unit.

HM Inspectorate of Prisons

27. The most recent inspection of HMP Hewell was in September 2016. Inspectors reported that drugs were widely available. 60% of prisoners, against the comparator of 39%, said it was easy to get drugs, and 16% said they had developed a problem with illicit prescription medication in prison, against the comparator of 8%.
28. Mandatory drug testing rates were rising and had exceeded the target for the previous six months. Suspicion testing was in place and 19 tests had been conducted during the six months to July 2016, with a reasonable positive rate of 36.8%, mostly for cannabis.
29. Despite the prevalence of drugs, supply reduction initiatives were developing well and there was effective joint working between security and other departments represented at the drug strategy committee.

Independent Monitoring Board

30. 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 30 September 2017, the IMB reported that incidents involving psychoactive substances (PS) were regularly reported in the daily briefing and, as they had said in their previous report, the ready availability of such illicit drugs put prisoners and staff at risk. The attendant problems of debt, bullying, intimidation and violence were evident across the Prison Service. PS incidents also added to the demand for emergency services.

Previous deaths at HMP Hewell

31. Mr Garratt was the fifth prisoner to die at HMP Hewell in 2018. Of the previous deaths, one is currently subject to a police investigation, one was from natural causes, one was drug-related, and one is still being investigated. There has been one further deaths since Mr Garratt's, this is believed to have been from natural causes.

Psychoactive Substances (PS)

32. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a problem across the prison estate. They are difficult to detect and can affect people in several 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.

33. 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.
34. 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

35. Mr John Garratt was released from prison on licence on 23 June 2017. He was recalled to prison on 20 October 2017 after displaying poor behaviour in the community and on 23 October, he was sent to HMP Birmingham. His prison records show that Mr Garratt displayed frequent poor behaviour toward staff and did not comply with prison rules.

HMP Featherstone

36. On 10 January 2018, Mr Garratt was transferred to HMP Featherstone. His poor custodial behaviour continued at Featherstone, with numerous accounts of him making threats of violence toward staff and fighting with other prisoners.
37. Mr Garratt was found to be under the influence of PS on eight separate occasions between February 2018 and June 2018. After each occasion, he was referred to the prison's substance misuse team, who offered advice and support, but he refused to engage.
38. On 20 August, he threw urine and faeces over an officer. As a result, he was moved to the segregation unit, where his behaviour continued to be confrontational and non-compliant.
39. On 24 August, he smashed up his cell and later complained that he had hurt his hand. The following day he was taken to A&E for an x-ray which showed no bones were broken. He was placed on suicide and self-harm prevention measures (ACCT) as he said he had smashed up in order to self-harm. During ACCT reviews he said he wanted help with paranoid feelings and bereavement counselling and was advised to seek these at his next prison as he was about to be transferred. The ACCT was closed on 29 August as he said he had no further thoughts of self-harm. He was told the ACCT could be re-opened if he felt he needed additional support.
40. On 31 August, he was transferred to HMP Hewell for what Mr Garratt and staff hoped would be a fresh start.

HMP Hewell

41. On his arrival at Hewell, Mr Garratt was assessed by a nurse. During the assessment Mr Garratt was asked whether he had issues with alcohol or drugs and replied that he did not. He was asked about any current or previous acts or thoughts of self-harm. Mr Garratt said that three years ago he had attempted to hang himself while under the influence of PS. However, he said he had no current thoughts of self-harm or suicidal ideation. The nurse recorded that Mr Garratt presented as calm and engaging, and concluded that he did not need monitoring under ACCT.
42. The nurse recorded that Mr Garratt was being prescribed olanzapine (an anti-psychotic medication) and sertraline (an anti-depressant). Mr Garratt told him that he suffered from drug-induced psychosis, anxiety and depression, and would like to engage with the prison mental health team. He submitted a routine referral for Mr Garratt to be assessed.

43. The following day, Mr Garratt attended an appointment for a secondary health screening but walked out before being seen, without giving a reason.
44. Mr Garratt was located in cell 3-20 in house block 3. He occupied the cell on his own. There is nothing recorded in his prison record between Saturday 1 September and Wednesday 5 September. Staff told the investigator that some wing staff had experienced minor issues with Mr Garratt being verbally abusive over the weekend, but they said that this had not resulted in any sanctions and there had been no other issues.

Events on Wednesday 5 September

45. On the morning of 5 September, all prisoners were provided with breakfast and a packed lunch. They were then locked in their cells from 9.00am and would remain there until the afternoon, unless employed in the prison kitchens or attending legal visits. This was to facilitate staff training, which was followed by a full staff meeting with the Governor between 11.45am and 12.30pm.
46. While the training and full staff meeting were taking place, a few staff were asked to remain on the house blocks to answer the emergency cell bells and observe those prisoners who were being monitored under ACCT.
47. An officer attended training that morning, but told the investigator that instead of attending the full staff meeting at 11.45am, he volunteered to remain on house block 3 to monitor those prisoners on ACCT and answer the cell bells.
48. The officer told the investigator there were several prisoners being monitored under ACCT procedures that day. One of these prisoners, who was being observed four times an hour, was located in cell 3-17, three doors along from Mr Garratt's cell. CCTV shows him carrying out observations on this prisoner at 12.05pm and 12.20pm.
49. When a prisoner presses their emergency cell bell, a light comes on outside their cell and buzzer sounds in the wing office, indicating to staff that a prisoner's cell bell has been pressed.
50. Mr Garratt's cell bell was pressed at 12.30pm and at the same time the officer can be seen on CCTV leaving the landing. He said he did not see that Mr Garratt's cell bell was illuminated at the opposite end of the landing.
51. The officer returned to the wing office where he muted the buzzer from Mr Garratt's cell bell, and recorded that he had completed an ACCT check on the prisoner three doors down from Mr Garratt at 12.35pm. CCTV shows this check was not carried out as recorded - no officers can be seen on the landing between 12.30pm and 12.45pm.
52. Another officer had attended the full staff meeting and returned to house block 3 at around 12.40pm. He went to check on the prisoner in cell 3-17 after noting that an ACCT observation was due. After completing the observation, he saw that Mr Garratt's cell bell was illuminated and went to answer it at about 12.46pm. (He had not heard the buzzer in the wing office because it had been muted.)

53. The officer has now left the Prison Service and we were not able to interview him. However, in a statement written shortly after the incident, he said that as he got close to Mr Garratt's cell, he could smell burning but there was no smoke visible. He looked in the cell via the observation panel and said at first glance he thought the observation glass was covered by tissue paper. He called to Mr Garratt and asked what the problem was, and Mr Garratt said, "Help me boss." He could not see Mr Garratt.
54. The officer said he then realised that the obstruction in the observation panel was smoke and immediately used his radio to alert staff to a possible cell fire and request assistance. This triggered the control room to request fire service assistance.
55. The officer said that he ran down to the landing below and grabbed a smoke hood before returning to the 3s landing and collecting the high pressure misting equipment, which he took to Mr Garratt's cell door. By this time, a significant number of staff had responded to his initial radio call and other staff had collected protective equipment including smoke hoods.
56. The Health, Safety and Fire Manager at Hewell told the investigator that all operational staff were trained in dealing with fires and that equipment and smoke hoods were located on each house block. Cell doors have a removable bung, known as an inundation point, that allows a hose to be used to spray water into a cell without opening the door. She said that under national fire safety guidance the expectation is that staff will begin inundating a cell within five minutes of a fire being detected and had done so in this case. Staff were trained not to open a cell door until the fire had been extinguished because doing so could cause a flash fire and result in injuries. She said that, as a guideline, they would expect a prisoner to be removed from a cell where there had been a fire and into clean air within 20 minutes. She said that timeline was met in this case.
57. The Health, Safety and Fire Manager said that the majority of cell fires were caused when a prisoner set fire to rubbish in a waste bin as a protest and were minor affairs which caused no injuries. There was no reason initially to think that the fire in Mr Garratt's cell was any different, but the response would be the same for all such incidents.
58. CCTV shows that staff began inundating Mr Garratt's cell by 12.48pm, within three minutes of the officer's initial emergency call. While doing so, staff continuously attempted to talk to Mr Garratt, but he did not respond.
59. At 12.59pm, when staff entered the cell, they found Mr Garratt sitting on the side of the lower bunk bed, with his feet on the ground. They attempted to communicate with him but, although Mr Garratt was conscious, he appeared unable to comply with their instructions, and when they attempted to help him get up from the bed, the skin on his arms came away (which was traumatic for staff) and they realised they were going to have difficulties getting him out.
60. At this point, the staff who had initially entered the cell were withdrawn. Staff who had been dealing with a Control and Restraint (C&R) incident and had attended the cell fire in case they were required, entered the cell and helped Mr Garratt to his feet and into an empty cell next door. (The investigator was told

that the C&R team were not used because Mr Garratt needed to be restrained but because they happened to be on site and were bigger and stronger than the other staff and so more able to lift Mr Garratt and help him out of the cell.)

61. A Mental Health Nurse told the investigator that he heard the cell fire being called over the radio and, although there was no call for healthcare staff, he decided to walk over to offer support as he was covering the first responder role. He said it took him three or four minutes to get there and, when he arrived, staff were inundating the cell to put the fire out. There was no information on whether Mr Garratt had been injured. There were no other healthcare staff there and he asked the Deputy Governor, who was present, if they had been called. She said they were busy putting the fire out, so he called for healthcare assistance himself.
62. The Mental Health nurse said he then went to collect the house block's emergency bag and defibrillator and started to prepare the oxygen mask in case it was required. While he was doing so, a nurse arrived and they were both on hand with emergency equipment to begin treating Mr Garratt when he was taken from his cell at 1.00pm. At this point an emergency ambulance was called.
63. The nurse said that Mr Garratt was assisted into the empty cell, away from the smoke, and on seeing the extent of his burn injuries, she immediately radioed for further healthcare assistance. She said that she updated the control room on the serious nature of Mr Garratt's injuries. He had burns and blistering to most of his body but not his face, although he had singeing to his hair and eyelashes, soot in his mouth and on his teeth, and his tongue was swollen. His clothes had been completely burnt, leaving him naked apart from the waistband of his jogging bottoms which she cut off.
64. There was very little fire damage to the cell or furniture and it appears that the fire had been almost entirely confined to Mr Garratt's body.
65. Despite the severity of his injuries, and the fact that he was in a lot of pain, Mr Garratt was fully alert, orientated and co-operative. The nurse said that he said twice that he had not meant to do it.
66. The Deputy Head of Healthcare arrived at about 1.05pm in response to the nurse's call for assistance. When she saw the extent of Mr Garratt's injuries, she confirmed with the duty Governor (who was present) that an ambulance had been called and then asked that the ambulance service be informed that it was a 'category one situation' (the highest priority).
67. An on-site paramedic also arrived at about 1.05pm after dealing with a separate incident. He said he heard a call for all healthcare staff to attend, so he knew it was a serious incident and took his emergency bag. When he arrived on the house block, he was shown to the cell where two nurses were treating Mr Garratt. They had a burns kit, but due to the extent of his burns, they did not have enough dressings, so the on-site paramedic handed his burns pack to them. He said that a nurse had established a good rapport with Mr Garratt and was talking to him about everything that was going on. He said that it was clear that Mr Garratt was in some discomfort, but was dealing with it 'really well'.

68. The nurse said that she needed intravenous (IV) access to administer fluids and pain relief, and the on-site paramedic began assessing where IV access would be possible. He was unable to see or feel any veins and asked staff to update the ambulance crew and request that they bring an intraosseous infusion (IO) kit to the scene. (IO is the process of injecting directly into the marrow of a bone and is used to provide fluids and medication when access via a vein is not feasible.)
69. While waiting for the ambulance, the on-site paramedic continued to look for suitable IV access, helped by a prison GP who had arrived. They identified that Mr Garratt's foot might provide a suitable site but, as they were assessing it, the ambulance crew arrived at 1.20pm. The ambulance staff then took over treatment and Mr Garratt was given fluids and pain relief. The Helicopter Emergency Medical Service had also been sent, as this was a category one emergency call, and a discussion took place about whether to transfer Mr Garratt to hospital by air or road. It was decided that he would go by road, and he was transferred to the waiting ambulance and taken to the burns unit at the Hospital in Birmingham.
70. Two members of prison staff escorted Mr Garratt to hospital, but no restraints were used.
71. A subsequent search of Mr Garratt's cell found that bare wires had been exposed on the kettle and that there was a vaping device on the bed that had been adapted. (Prisoners are not allowed lighters and use both mechanisms to obtain a light to smoke illicitly.) The Fire Service suggested that the vaping device was the most likely ignition point. Staff believed that Mr Garratt was under the influence of an illicit substance, most likely PS, when he caught fire.
72. Mr Garratt had burns to 83% of his body, including some full thickness burns. He underwent several procedures in hospital over the next 36 hours, but specialists at the burns unit indicated that his injuries were not survivable. On the morning of 7 September, treatment was withdrawn on the advice of specialists and at 12.05pm, it was confirmed that Mr Garratt had died.

Contact with Mr Garratt's family

73. A safer custody manager, a manager and the appointed Family Liaison Officer visited Mr Garratt's next of kin on the afternoon of 5 September and told them that Mr Garratt had been taken to hospital. The next of kin attended the hospital to be with Mr Garratt. The family remained at Mr Garratt's bedside and were with him when he died.
74. The prison contributed to the cost of the funeral in line with Prison Service instructions.

Support for prisoners and staff

75. After the incident on 5 September, the duty governor 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.

76. On 7 September, the prison posted notices informing other prisoners of Mr Garratt'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 Garratt's death.

Post-mortem report

77. The post-mortem concluded that the cause of Mr Garratt's death was "extensive full thickness and partial thickness burns, with smoke inhalation also contributing to death".
78. Toxicology tests showed low levels of ketamine, paracetamol and dihydrocodeine present in Mr Garratt's system. The pathologist said that these were probably administered as painkillers by the paramedics and hospital staff.
79. The toxicology tests also showed the presence of PS in Mr Garratt's system, indicating that he had used it before his death.

Findings

Substance misuse

80. Mr Garratt had a history of illicit drug use, including long-term PS use. He was offered support from the substance misuse service at Featherstone, although he did not always engage. Prison staff also provided advice and guidance, reminding him of the potential dangers of PS use, and responding appropriately when he was found under the influence of PS.
81. He was only at Hewell for five days. When he arrived at Hewell, he denied that he had any issues with drugs and did not co-operate with attempts to complete his health screening.
82. We are satisfied that Mr Garratt was offered appropriate support and advice with his substance misuse issues. We are, however, concerned that he was able to access drugs with apparent ease and we address this later.

Clinical care

83. The clinical reviewer concluded that overall the care Mr Garratt received at Hewell was equivalent to that which he could have expected to receive in the community.
84. Mr Garratt had only been at Hewell for five days, during which time he had not co-operated with attempts by both nursing staff and the GP to review him. He had asked to engage with the mental health services, but the request had not yet been actioned due to the brief period of time he had been at Hewell.
85. The clinical reviewer recommended in her report that healthcare staff should be commended for the emergency care provided to Mr Garratt during a traumatic and distressing incident, ensuring that he received the best possible care in very difficult circumstances. We agree.
86. She also recommended that healthcare staff be reminded of the importance of keeping accurate records as she was concerned that a nurse and an on-site paramedic had not made any notes in Mr Garratt's medical record about their role in the emergency response. The Head of Healthcare at Hewell will want to address this.

Response to Mr Garratt's cell bell

87. When a prisoner presses their emergency cell bell, a light comes on outside the cell door and on a panel in the wing office and a buzzer sounds in the wing office. The buzzer can be muted in the wing office. The Prison Service expects cell bells to be answered 'promptly' and HMIP has an expectation that cell bells should be answered within five minutes, other than in exceptional circumstances.
88. An officer who was on house block 3, by himself while other staff attended a staff meeting, told the investigator that he was aware that he was responsible for checking on prisoners subject to ACCT monitoring and for answering emergency cell bells on the three spurs. He was also expected to report the wing roll.

89. The officer recorded in the ACCT document that he completed three ACCT observations on the prisoner in cell 3-17 (three doors down from Mr Garratt's cell), the third being conducted at 12.35pm. However, CCTV shows that he did not conduct an ACCT observation after 12.20pm.
90. CCTV shows that Mr Garratt's cell bell came on at 12.30pm. The officer accepted that he had muted the buzzer in the office and did not answer Mr Garratt's bell. He said that he was aware of the expectation that cell bells will be answered as soon as possible, and at least within approximately five minutes. He said that he did not answer Mr Garratt's cell bell because he was trying to collate the roll, a task he had never done before, and he was 'panicking' because it was due to be submitted at 12.30pm, the office was in a bit of a mess and he could not find the numbers. He said he was chased for the roll count by a Supervising Officer when they returned from the staff meeting, and when he did put the numbers in, they were incorrect and he felt under pressure to stay in the office and sort it out.
91. This meant that Mr Garratt's bell was not answered for approximately 16 minutes until another officer noticed the light on outside Mr Garratt's cell, went to answer it and raised the alarm.
92. We do not know how long Mr Garratt had been burning for before he pressed his cell bell. If he was under the influence of PS, he may have passed out or not realised he was on fire, or he may have been physically unable to move (as PS can cause a kind of temporary paralysis).
93. However, as part of our investigation we sought the clinical opinion of a burns specialist, on whether a delay of 16 minutes in responding to the cell bell would have affected the outcome for Mr Garratt. The Clinical Service Lead for Burns said that in his opinion, the delay 'definitely affected the outcome' for Mr Garratt.
94. We note that if another officer had not seen that Mr Garratt's light was on and gone to answer it, Mr Garratt's bell would have remained unanswered for even longer.
95. We recognise that the officer did not know why Mr Garratt had pressed his bell and that prisoners sometimes press cell bells for trivial reasons. We also recognise that the he was working on his own and had a number of tasks to complete. However, he had volunteered to remain on the house block, and we do not consider it was acceptable to have muted an emergency cell bell and left it unanswered for 16 minutes. In addition, it was not acceptable to have recorded that he had carried out an ACCT observation on a prisoner in a nearby cell at 12.35pm, when he had not done so.
96. We make the following recommendation:

The Governor should commission an internal investigation into the actions of the officer on 5 September 2018 with a view to considering if disciplinary action is appropriate.

The Governor should ensure that staff respond to all cell bells 'promptly', that is within five minutes other than in exceptional circumstances.

Emergency response

97. Prison Service Instruction (PSI) 11/2015, *Fire Safety in Prison Establishments*, provides instruction and guidance on procedures to be followed to manage the risks of fire.
98. An officer reacted promptly when he realised there was a fire in Mr Garratt's cell. The PSI says that on discovery of a cell fire staff should raise the alarm, collect protective equipment, inundation key, hose reel and water mister, put on protective equipment and begin inundation. He followed this guidance and staff began inundation within three minutes. The local fire service was also called.
99. The PSI provides guidance for staff dealing with a cell fires with three distinct types of occupants: compliant, non-complaint and unresponsive. Mr Garratt was considered to be unresponsive as staff continued to try and speak to him as they inundated the cell, but he did not respond. In such situations the guidance states that staff should inundate the cell, consider whether it is safe to enter the cell, and, if not, continue to inundate until it is considered safe to enter or until relieved by the fire service.
100. The inundation lasted for a total of 11 minutes before staff entered the cell. This clearly caused a further delay before Mr Garratt was able to receive medical help. We note that the Health, Safety and Fire Manager was satisfied that this was not an excessive length of time to put the fire out and bring Mr Garratt out. This is, however, outside the PPO's area of expertise and we cannot express an opinion.
101. PSI 03/2013, *Medical Response Codes*, requires prisons to have a two code medical emergency response system. Hewell's local policy instructs staff to use a code blue to indicate when a prisoner is unconscious or having breathing difficulties, and a code red when a prisoner is bleeding or badly burned. Calling an emergency medical code should automatically trigger the control room to call an ambulance, and for healthcare staff to attend with the appropriate emergency equipment.
102. In this case, although a mental health nurse called for healthcare assistance when he first arrived before Mr Garratt's condition was known, and a nurse called for all healthcare staff to attend when she saw the extent of Mr Garratt's injuries, there is no evidence that anyone called an emergency medical code. This should have been done as soon as prison staff entered the cell and realised that Mr Garratt was badly burned. Although healthcare staff attended, the failure to call an emergency code meant that the control room did not call an ambulance straightaway. Although the delay was unlikely to have changed the outcome for Mr Garratt, given the seriousness of his injuries, in other circumstances, any delay could be crucial. We recommend:

The Governor and Head of Healthcare should ensure that all staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that staff promptly use an emergency code to effectively communicate the nature of the emergency.

103. The two nurses who initially attended the cell fire, had to wait for inundation to be completed before they were allowed to access Mr Garratt and begin treating him. We agree with the clinical reviewer that healthcare staff responded promptly and effectively in extremely difficult circumstances.

Psychoactive Substances

104. Hewell is aware of the very serious issues it faces with illicit drugs and is being proactive in trying to tackle them. However, we are concerned that Mr Garratt was able to access PS within five days of arriving at Hewell, which suggests that PS was readily available and that more needs to be done to prevent drugs entering the prison.
105. Hewell is not alone in facing the problems caused by PS and other drugs. It is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, in our view there is an urgent need for national guidance to prisons from HMPPS providing evidence-based advice on what works.
106. In several recent investigations, we have recommended that the Chief Executive of HM Prison and Probation Service (HMPPS) should issue detailed national guidance on measures to reduce the supply and demand of drugs, including PS, in prisons. The Acting Ombudsman also wrote to the Prisons Minister raising her concerns about the high number of deaths she was investigating that were due, or linked, to the use of PS. The Chief Executive told us that HMPPS planned to issue a national drug strategy in the autumn of 2018. We are concerned that at the time of writing (March 2019), this strategy has still not been issued. We therefore make the following recommendation:

The Chief Executive of HMPPS should provide the Ombudsman with a revised date for issuing detailed national guidance on measures to reduce the supply and demand of drugs in prisons, and an assurance that this new date will be met.

**Prisons &
Probation**

Ombudsman
Independent Investigations