

**Investigation into the circumstances surrounding
the death of a man in November 2011 at a hospital while
still a serving prisoner at HMP Holme House**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

November 2012

This is the report of an investigation into circumstances surrounding the death of a man in November 2011. He died as a result of smoke inhalation after starting a fire in his cell at HMP Holme House the previous day.

The man had been taken from court to HMP Holme House on 31 October 2011. His behaviour over the next 48 hours was volatile and unpredictable. He spent time in the healthcare centre and the segregation unit. He was assessed by a number of clinical staff, and although he was a known abuser of alcohol, no withdrawal symptoms were observed. He was checked regularly and he was moved to the first night centre. However, almost immediately, he assaulted two prisoners, barricaded himself in his cell and started a fire. The fire took hold quickly and staff risked their own safety to enter the cell and drag him out. Unfortunately, despite their efforts, he did not recover and the post mortem found that he died from brain damage caused by smoke inhalation.

The investigation was completed by a senior investigator and an Assistant Ombudsman. One of my family liaison officers contacted the man's relatives to discuss the investigation. The investigation was suspended while the police determined whether to pursue a charge of corporate manslaughter against the National Offender Management Service. They eventually decided not to press charges and we are now publishing our draft report, albeit a little later than we otherwise would do.

A review of the clinical care which the man received in prison was undertaken by another investigator and a clinical reviewer appointed by the local PCT. They conclude that, allowing for a range of extenuating circumstances, he received care equivalent to that which he could have expected in the community.

The man's behaviour was erratic and difficult to manage. Once he had barricaded himself into his cell and started the fire, there was very little chance of him surviving because of the volume of smoke which engulfed him so rapidly. Nonetheless, the report also highlights the tenacity and bravery of the staff at Holme House who sought to save him. The six men and women who tackled the cell fire showed immense courage, especially when they continued in their efforts to extricate him from his cell after their protective equipment had started to fail. This put them at great personal risk and their actions were little short of heroic. I trust this will be recognised.

However, the investigation also identifies a number of systemic failures in the fire safety processes at Holme House. Some of these failures require lessons to be learnt at a national level. Although some of the recommendations directed at the establishment have significant cost implications at a hugely difficult economic time, they will also have to be considered more broadly by the National Offender Management Service. What is clear is that there must be no unnecessary compromise in the search for improved fire safety in prison in the aftermath of this tragic case.

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

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Prisons and Probation Ombudsman

November 2012

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SUMMARY

1. The man had a long history of alcohol misuse. He was arrested in the early hours of 31 October 2011 for offences of criminal damage. He was taken to Magistrates' Court and remanded into custody.
2. At about 4.00pm that day, the man arrived at HMP Holme House. While in the reception area, he suddenly became aggressive. He tried to throw his tray of food over one officer and punch another. Three officers and a senior officer used control and restraint techniques to protect themselves and keep him safe. They escorted him to the segregation unit.
3. Prisoners need to be assessed by a member of healthcare staff when they arrive in prison. Because the man had become violent, the nurse in the reception area had not had the chance to complete her assessment. She consulted a doctor and they agreed that he, who was known to misuse alcohol in the community, should not be held in the segregation unit without a proper health assessment. He was therefore taken to the healthcare centre overnight, where he was checked by a doctor. The doctor did not diagnose any symptoms of alcohol withdrawal.
4. The man became aggressive again early on 1 November. He vandalised his cell and smashed a television. He was seen by a nurse who referred him for further drug and alcohol assessment. He was then moved to the segregation unit, where he flooded and vandalised his cell. He was checked by a doctor and a nurse with mental health training, who completed the first night reception health screening which would normally have been completed the previous day. He remained in the segregation unit overnight.
5. The next morning, 2 November, the duty governor was due to hold an adjudication panel with the man because of his behaviour since his arrival. However, he suspended the process. He wanted him to undergo further assessment because his behaviour was still giving cause for concern. He was discussed at the daily healthcare handover meeting and it was decided that a referral should be made to the mental health in-reach team. The nurse who had assessed him the previous day was asked to make a referral. She checked on him in the segregation unit.
6. During the afternoon, another doctor and a pharmacy technician assessed the man. Neither found any sign of withdrawal symptoms and the doctor agreed that he could be moved to the first night centre on C wing on Houseblock 4, where there is 24 hour nursing cover. Indeed, none of the healthcare staff who had examined him since his arrival had observed any signs of withdrawal.
7. The man was taken to the first night centre. He moved into a double occupancy cell on the third landing on his own because he was assessed as presenting a high risk to other prisoners. He went to collect his meal and assaulted two prisoners of black and minority ethnic origin. He was taken

back to his cell and locked inside. He then barricaded himself into his cell and threatened to hurt staff if they tried to gain entry.

8. While the wing manager telephoned the duty governor and the orderly officer for advice, the man started a fire behind his cell door. Thick black smoke immediately started billowing onto the landing. It seems likely that another prisoner on the landing raised the alarm by shouting, although this remains unclear. An officer then pressed the general alarm instead of the fire alarm. The in-cell smoke detection system did not activate as it was supposed to. Instead, smoke rising on the landing triggered the fire alarm. This caused the vents in the roof to open, but instead of the smoke dissipating as intended, it gathered on the wing.
9. Six members of staff trained in the use of cell snatch rescue equipment (CSRE) made their way to the scene and tackled the cell fire. They put on smoke hoods, which proved effective in keeping the smoke out but made communication difficult. Some staff lifted their hoods to shout instructions. The officers were unable to use the access point for the hose in the cell door because it had seized. Instead, they smashed the glass in the observation panel and inserted a hose.
10. The officers tried to push the door open but the barricade was still in place. They asked for a tool to remove the anti-barricade stop so that they could open the door outwards. However, the officer with access to this tool had left the wing to help evacuate prisoners to the gym. The orderly officer had to send another officer to collect the key to the tool cabinet from his colleague. Consequently, there was a delay in bringing the tool to the cell door.
11. Once the stop was removed from the cell door, four officers entered the cell, which was full of smoke and pitch black. They used their hands to touch the walls and floor, searching for the man. They found him by the toilet in the corner of the cell, dragged him out and the officers and nurses began cardiopulmonary resuscitation. He was taken to hospital but did not recover from the fire and died the following day. The staff who tackled the fire were taken to hospital and treated for smoke inhalation.
12. The investigation has revealed that the fire prevention systems at Holme House were inadequate. We are concerned that the in-cell detection system, smoke extraction system in the roof and access point for the hose in the cell door all proved ineffective. However, we commend the actions of the staff who tried to save the man. We also think that staff did their best during the preceding 48 hours to manage his risk and regularly check his health. We make 13 recommendations as a result of the investigation.

THE INVESTIGATION PROCESS

13. The investigators were told about the man's death on 4 November 2011. Notices were issued to staff and prisoners at HMP Holme House telling them about the investigation process and inviting them to contact the investigator. No prisoners asked to speak to the investigators.
14. The investigator liaised with a Senior Officer and a Governor during the investigation. He visited Holme House on 7 November to speak to staff, look at the man's cell and collect paperwork relating to his time in custody. He visited the induction unit, the healthcare centre, the segregation unit and the reception area.
15. The investigator contacted the healthcare provider to ask that a review be carried out with regard to the clinical care the man received in custody. The purpose of the review is to establish whether the care which he was offered in prison was comparable with that he could have expected in the community. Another investigator and a clinical reviewer completed the review.
16. During the investigation, the investigator liaised with a number of agencies also charged with examining the cell fire which caused the man's death. The Crown Premises Inspection Group (CPIG), Health and Safety Executive (HSE) and Cleveland Police have all conducted their own enquiries. Additionally, the National Offender Management Service (NOMS) conducted their own internal investigation of the cell fire, led by the Governor of HMYOI Wetherby. The investigators also met the Head of Fire Safety at NOMS.
17. Both investigators visited Holme House on 7 and 8 December to interview 15 members of healthcare and discipline staff.
18. Our investigation was then suspended while the police gathered evidence and took advice to determine whether they should take further action in relation to the man's death. The investigators attended a meeting at Stockton Police Station on 13 March 2012. They met representatives from CPIG, the HSE and the police. On 23 April, an investigator was informed that the police had decided not to bring any charges. He then confirmed with CPIG that this draft report would be completed and published.
19. The investigator wrote to the local Coroner at the start of the investigation to inform him of its nature and scope. HM Coroner will be provided with a copy of our report.

The man's family

20. One of our family liaison officers contacted the man's sister and partner on 2 December to discuss the investigation. His sister said that the family wanted to know more about the circumstances of her brother's death. She wanted to know how quickly staff had responded to the cell fire and what efforts had been made to remove her brother from the cell.

21. The man's partner did not believe that he had set the fire with the intention of harming himself. She thought that he had probably been trying to antagonise prison officers and events had spiralled out of control. She asked whether he had been withdrawing from alcohol and whether he should have been kept in the healthcare centre. She also asked how long it had taken staff to enter the cell and what efforts had been made to get him out of the cell. She praised the polite and courteous escort officers who she met when she visited her partner in hospital.
22. We hope that the report helps the man's relatives to better understand the circumstances surrounding his death. We have included the response from his partner to the draft report.

HMP HOLME HOUSE

23. HMP Holme House holds male prisoners arriving from courts in the North East of England. The accommodation consists of seven houseblocks. The prison holds a maximum of 1212 men. The acting Governor of Holme House at the time the man died and his acting deputy governor have been replaced since the incident.
24. The man had just moved to Houseblock 4 when he started a fire in his cell. Houseblock 4 contains the first night centre and the Integrated Drug Treatment System (IDTS) unit. (IDTS is a recently implemented treatment regime offering standard care for drug users throughout prisons in England.) Houseblock 4 has 24 hour nursing cover to monitor prisoners who might be withdrawing from drugs or alcohol. IDTS prisoners can remain on the wing for up to 28 days while they undergo treatment for withdrawal.
25. Houseblock 4 was completed in 1995. It was designed to comply with the fire safety measures recommended by the Prison Service at the time, including detector beams in wing roofs to detect smoke in the communal areas, natural smoke venting in the wing roofs, hose reels on wing landings and inundation ports in cell doors. The building meets current fire safety standards adopted by the National Offender Management Service (NOMS) and Holme House's fire safety management arrangements comply with the NOMS fire safety model.
26. Holme House has an inpatient healthcare centre with 28 inpatient cells. The man spent time in one of the cells in the healthcare centre, which has 24 hour nursing cover. The segregation unit, where he was also held, has 32 cells.

HM Inspectorate of Prisons

27. HM Chief Inspector of Prisons conducted a full unannounced inspection of Holme House between 19 and 23 July 2010. He made the following comments:

'Prisoners in our groups expressed dissatisfaction with health services. In our survey, fewer prisoners than the comparator rated the quality of the service from doctors and nurses as good or very good. We observed health services staff behaving professionally and patients being treated with respect.

'The induction room on Houseblock 4 was comfortable and well equipped. Induction generally started on the first working day following arrival at the prison. Dedicated induction staff, although not specifically trained, were enthusiastic and showed concern for meeting the immediate needs of prisoners.

'The segregation unit was clean and all cells had in-cell sanitation and were in good order... Staff-prisoner interaction was good and the prisoners that we spoke to were positive about the staff... Few of the

unit staff (or adjudicating governors) had undergone any mental health awareness training...

'The use of force was low, at 9.7 uses per 100 prisoners, but had increased from 151 uses in 2009 to a projected 192 (96 in the first six months) in 2010. A review of all uses of force between April and June 2010 showed that, of 65 recorded incidents, nine had not involved any form of restraint and 45 had included the use of handcuffs, predominantly for prisoners being taken to the segregation unit (although some managers had not authorised handcuffs to be used). Two of the uses of force we reviewed were disproportionate, involving one prisoner who refused to clean up food he had thrown and another who threw a chair in his cell following an IEP review.'

28. The Chief Inspector made the following recommendation:

'Prisoners should not be routinely handcuffed when being taken to the segregation unit.'

Independent Monitoring Board

29. The Independent Monitoring Board (IMB) at Holme House most recently published an annual report dated 2010. The IMB at each prison is made up of members of the local community who are both independent and unpaid. They monitor the day-to-day life in the prison and ensure that proper standards of care and decency are maintained. The Board made the following comments about Holme House:

'The Board considers that the Prison was, overall, well managed in the year under review and that prisoners are treated with the respect to which they are entitled.

'The staff in the Segregation Unit continue to deal with some very troubled prisoners in a sympathetic and effective manner. The Board Member on rota will visit the Seg several times in a rota week, and it is pleasing to note that the atmosphere in the Unit is almost always warm and the vast majority of those detained in the Unit seem genuinely appreciative of the Unit's work.'

Crown Premises Inspection Group (CPIG)

30. The Crown Premises Inspection Group (CPIG) is the enforcing authority for general fire precautions in government buildings, including all prisons in England and Wales. Before 1 October 2006, the Prison Service had no statutory duty under fire safety legislation for the safety of prisoners. However, the Regulatory Reform (Fire Safety) Order 2005 came into force on that date, obliging the Prison Service to keep prisoners (as well as staff) safe in the event of a fire.

Previous investigations of cell fires

HMP Durham 2005

31. Since taking responsibility for investigating deaths in custody in 2004, this office has investigated two other deaths resulting from cell fires. A prisoner died in June 2005 at HMP Durham after starting a fire in his cell in the segregation unit. Like the man, the prisoner was volatile, unpredictable, angry and disruptive as soon as he arrived in the reception area. Like the man, he destroyed the property in his cell in the healthcare centre and was moved to the segregation unit because he had rendered his healthcare cell unusable. Just as at Holme House, during the cell fire staff thought that the prisoner might be armed, and were similarly beaten back by thick black smoke.
32. However, unlike the man, he was subject to self harm monitoring when he died and had previous convictions for arson. We thought that staff might therefore have identified the possibility of a cell fire and the risks associated with letting the man keep a cigarette lighter on his person. The Ombudsman found that the man's death was preventable because information about the risk of fire setting was not properly communicated. We have not made the same judgement about the man's death.
33. The investigation at Durham highlighted the lack of staff there who were fire safety trained. In particular, it found that none of the governor grade staff were trained. The Crown Premises Inspection Group (CPIG) was critical of this failure to train enough of the right staff. The investigation into the man's death has highlighted an identical problem at Holme House some six years later, as we go on to discuss.
34. We described the efforts of staff at Durham to rescue the man as heroic and brave and commended their actions. These are words that we use again in this report to describe the actions of the staff at Holme House, and once again we commend the officers involved.
35. Following our investigation at Durham, we recommended that the Prison Service review the fire safety equipment available to staff in order to ensure that officers were able to enter smoke affected areas at the earliest opportunity to rescue prisoners. The Service has since introduced cell snatch rescue equipment (CSRE). One of the lessons learnt at Durham was the need for an anti-barricade allen key to be kept with the CSRE. This measure was only implemented locally. As we go on to discuss, regrettably this allen key was needed during the fire at Holme House and could not be easily located.

HMYOI Glen Parva 2007

36. Like the man, the man who died at Glen Parva barricaded himself into his cell before starting a fire. As at Holme House, the barricade made it difficult for staff to rescue the man and proved to be the biggest obstacle to his removal

from the cell. Like the man, the man at Glen Parva used free standing lockers to block the entrance to his cell.

37. The circumstances of the cell fire at Glen Parva were very similar to the incident at Holme House. Smoke billowed out from under the cell door and staff had to get past a barricade before dragging the man out. However, the fire at Glen Parva took place before the introduction of CSRE and the staff therefore did not have access to the smoke hoods used by Holme House officers.
38. Like the man, the man at Glen Parva had a history of alcohol misuse. However, unlike the man, the investigation found that the man almost certainly intended to take his own life by setting the fire. He had a history of serious and deliberate self harm. We were critical of the processes for monitoring self harm and of the mental healthcare provision at Glen Parva.
39. The investigation found that there was no permanent fire safety officer in post at Glen Parva. We are pleased to note that this was not the case at Holme House. The investigation also found that the fire service had not visited the prison to conduct an inspection four times a year as they were supposed to. The CPIG were critical of the lack of smoke detectors and sprinkler systems in cells and the absence of personal protective equipment (PPE) and breathing apparatus to prevent officers inhaling smoke during the rescue attempt.
40. During the attempt to rescue the man, staff eventually managed to use the anti-barricade allen key to remove the anti-barricade stop and open the cell door outwards. There was a significant problem in locating the key. During the cell fire at Glen Parva, staff considered this option in order to circumvent the barricade but decided against it because it would have taken valuable time to locate the key and, even then, there was no guarantee that the hole into which the key should be inserted had not been painted over.
41. Although staff were able to successfully use the allen key at Holme House, a similar concern was also raised by an officer during interview. She said that she had been trained to check the anti-barricade device during cell fabric checks for paint and other potential obstructions. We are concerned that these devices should be regularly checked across the prison estate.
42. After the man's death at Glen Parva, the CPIG approached the police to discuss whether a case for gross negligence manslaughter could be brought against the Prison Service. However, the police eventually determined that there would be insufficient grounds for prosecution.
43. We recognised and commended the courage of the staff at Glen Parva who tried to rescue the man. Unlike the earlier investigation at Durham, we found that it was impossible to be certain whether the man's death could have been prevented if staff had taken different steps with regard to his mental health and self harm monitoring.

HMP Leeds 2005

44. We also investigated the death of a man at Leeds who set fire to his cell two days before he hanged himself in the segregation unit. As happened at Holme House, staff were unable to unscrew the access point in the cell door in order to insert the hose nozzle. Like the staff who tried to rescue the man, the officers at Leeds had to smash the glass panel in the observation hatch using their batons. After the man was removed from his cell at Leeds, he told staff that it had been an attempt to take his own life.

KEY EVENTS

Recent custodial sentence

45. The man had 105 convictions for a total of 198 offences. He had a long standing problem with alcohol misuse. He had most recently been admitted to HMP Holme House for an offence of domestic violence on 9 June 2011, being released on 20 July. While he was in custody on this occasion, staff recorded that he fully participated in the wing regime.

Monday 31 October 2011

46. The man was arrested in the early hours of 31 October 2011. It was alleged that he had committed two new offences of criminal damage, visiting two residential addresses and breaking windows in both. He appeared at Magistrates' Court the same morning, where he was remanded into custody. He was then taken to Holme House. His next court appearance was scheduled for 8 November.

Reception at Holme House

47. Escort staff who transferred the man to Holme House recorded on the Person Escort Record (PER) that he was an alcoholic. (The PER is a document which staff complete when a prisoner is being escorted either to or from prison.) He arrived in the reception area at the prison at about 4.00pm. The Senior Officer (SO) going off duty spoke to another SO, who was beginning his shift in the reception area. He mentioned that he had been advised on the telephone prior to the escort van's arrival that he had defecated and soiled himself at court.
48. An officer booked the man into custody. The SO Forrest told the investigators that he appeared rambling and incoherent when he arrived. He presumed that he was intoxicated or drunk. Staff immediately offered him a shower and he accepted.
49. At about 4.45pm, the man was given his evening meal and taken to Holding Room Three in the reception area. However, he suddenly and unexpectedly tried to throw his tray of food over an officer. The officer managed to pull a door to in order to deflect the tray. He became verbally abusive. The other prisoners in Holding Room Three were unhappy, partly because of his agitation and also because some of them were covered in the food from the tray.
50. For the man's own safety, staff moved him to Holding Room One, where he was alone. The officers then offered showers to the other prisoners who had been affected. There was a camera in Holding Room One at the time, but the SO did not know this. The SO went to discuss his bizarre behaviour with an officer.

51. In the meantime, the man emptied a bottle of shower gel over the floor of Holding Room One. (He had hidden the bottle after his shower.) When staff discovered what he had done, he became abusive and angry. He was swearing and seemed incoherent. The officers thought his demeanour 'strange' and 'bizarre'.
52. The SO decided to move the man from Holding Room One to a camera cell so that he could be monitored for his own safety and the safety of staff. The SO told the investigators that, when a prisoner deliberately makes his cell floor slippery, staff interpret this as a signal that they are likely to resist.
53. Staff took the man by the arms to escort him to the camera cell. As they emerged from Holding Room One, he was flailing around. During interview, the SO likened his behaviour to a boxer. At about 4.55pm, he tried to throw a punch at an officer. The SO told the investigators that he was holding his body in an aggressive posture and had dipped down to the left.

Use of force

54. The officers realised that the man was not going to enter the camera cell willingly. As a result of his verbal and physical aggression, officers and the SO used authorised control and restraint techniques to escort him to the segregation unit.
55. Staff receive annual refresher training in control and restraint techniques to learn how to use the minimum amount of force necessary to safely protect staff and the prisoner. The SO, who oversaw the removal, had last received training in June 2011. A removal can sometimes be planned, if the prisoner's aggression is anticipated. It will then be filmed. However, in this instance the use of force was an immediate response to the man's behaviour. The use of force requires three officers and a manager to oversee the process. The SO told the investigators that he was satisfied with the way his staff used force to keep themselves and him safe.
56. One officer took the man's left arm, another officer his right arm and another officer his head. He did not comply with the officers' instructions to calm down and stop resisting, so the SO applied ratchet handcuffs. However, he ignored the SO's instructions and continued to resist. Staff did not use batons but continued to hold him in restraint as they escorted him to the segregation unit. He remained resistant throughout the process. He did not listen or respond to instructions.
57. As the officers left the reception area, another SO took over the use of force from the first SO so that the latter could stay and oversee the reception process. A nurse accompanied the officers and the man to the segregation unit and the officers removed the handcuffs when they reached the unit. He calmed down and apologised for his behaviour. Neither he nor the officers were injured during the use of restraint.

Segregation Unit

58. A governor was in the orderly office when she heard that force was being used by officers in the reception area. She walked over to the segregation unit and volunteered to complete the initial segregation safety algorithm form. (The algorithm is a step by step process to determine a prisoner's suitability. Stays in the segregation unit require the authorisation of a member of healthcare staff and a Governor. Each must assess that the prisoner reaches certain criteria and sign the algorithm form to confirm that the prisoner can be safely held on the unit.) She spoke to a nurse and he began to prepare an algorithm.
59. However, a Sister (a registered general nurse) was working in the reception area that afternoon performing first night health screenings for newly arrived prisoners. She is the senior nurse with responsibility for the reception process. She had not had the chance to meet or assess the man before he became aggressive and was moved to the segregation unit. She had been assessing other prisoners when she heard the disturbance in the reception area.
60. After the man was removed, the Sister checked what medication that he had brought into prison with him. She found vitamin B and thiamine, both of which are given to people who have alcohol misuse problems. She consulted a doctor and they both agreed that he would fail a segregation algorithm and should not stay in the segregation unit.
61. The Sister telephoned the segregation unit and advised that the man would fail the algorithm. She advised that his alcohol issues, volatile behaviour and general health had not yet been assessed and therefore she could not be sure that it was safe for him to stay in the segregation unit. She recommended that he be taken to the inpatient unit in the healthcare centre instead, and undergo a health check once he had calmed down. The governor agreed.

Healthcare centre

62. The governor and the nurse did not complete a segregation algorithm. It proved unnecessary because the man was never allocated a cell following the Sister's intervention. The governor and two SOs escorted him to the healthcare centre. The governor stayed with him in the association room while the healthcare staff found him a cell. Although he had been verbally abusive while under restraint, she told the investigators that he was calm and talkative while they waited there for a few minutes.
63. The man spent the night in the healthcare centre as an inpatient. Having spoken to the Sister earlier, the doctor was aware of his behaviour in the reception area. She assessed him in the healthcare centre after she had finished seeing the other reception prisoners. He was in bed and seemed relaxed and settled. She went into the cell and spoke to him. He claimed to

have taken a number of drugs, including several opiates (subutex, methadone, heroin and Oromorph).

64. The doctor wrote in the clinical record that the man appeared 'intoxicated' and that his pupils were 'pin point' (an indicator consistent with opiate use). She told the investigators that he seemed to be under the influence of a sedative or an opiate. He did not seem agitated or stimulated as he might have done if he had been drunk. She told the investigators that she did not prescribe withdrawal treatment. She thought that this would have been 'foolhardy' and potentially dangerous, given that he seemed settled. He showed no signs of withdrawal.
65. The doctor asked the nursing staff working overnight to observe and monitor the man for signs of drug and alcohol withdrawal. She also ordered a urine test. A nurse performed the test which showed evidence of diazepam (a prescribed benzodiazepine), cannabis and morphine. She informed the doctor of the result.
66. At about 6.00am the next morning, a nurse wrote in the clinical record that the man had become abusive and was demanding drugs. He was swearing and kicking his cell door. A registered mental health nurse (RMN) who works for the general nursing team rather than the mental health in-reach team also told the investigators that the man was loud and aggressive.
67. At about 7.00am, while locked in his cell, the man threw his television at the cell door, smashing it. Staff heard a loud bang and checked him. They witnessed him throwing other items around the cell. The RMN completed a report about the incident and immediately referred him to be assessed by a doctor.
68. A nurse assessed the man at about 9.50am. He referred him to RMDS (the local drug treatment provider) and the Counselling, Assessment, Referral, Advice and Throughcare Services (CARATS) team. (There is a CARATS team in each prison working with prisoners who misuse either drugs or a combination of drugs and alcohol.)
69. The man told the nurse that he had consumed £120 of heroin on Friday 28 October and misused alcohol (drinking three or four bottles of cider) on Sunday 30 October. He said that he was a frequent binge drinker but infrequent drug user. The nurse recorded that he looked quite well and had 'no florid symptoms of withdrawal' or obvious tremors, in spite of the substance misuse history he described. He appeared 'lucid and orientated' and was not sweating.

Segregation unit

70. The man was taken from the healthcare centre to the segregation unit at 11.45am because of the damage he had done to his cell, which was now out of use. He was due to attend an adjudication hearing in front of a governor

because of his behaviour. The move to the segregation unit was made for his safety and the safety of healthcare staff.

71. The RMN accompanied the discipline staff and the man on the short walk over to the segregation unit. She told the investigators that he remained verbally abusive but did not resist and was not physically aggressive. She approved the move and she and the governor signed off the segregation algorithm.
72. The man made threats and was verbally aggressive when he arrived in the segregation unit. He banged on his door, shouted and tried to flood his cell. He was still making verbal threats when the RMN left the segregation unit, but was not showing any overt signs of withdrawing from drugs or alcohol. He was demanding the medication he had brought into prison and some tobacco.
73. The RMN escorted the doctor to the segregation unit to assess the man at about 1.30pm. (The doctor does not carry keys.) Three officers from the unit stayed with the healthcare staff while they completed their assessments. The cell was flooded with water so the doctor and the RMN stood in the doorway while he sat on his bed. They stayed for about 25 minutes while each completed their assessments.
74. The doctor recorded that there was 'no evidence of withdrawal', that the man was talking coherently and that there was no sign of tremors or sweating. He said that he had been misusing his partner's Oromorph and MST tablets (both are opioid painkillers) and claimed that he regularly drank a bottle of vodka a day. (However, after his partner read our draft report, she told our family liaison officer that she had last taken MST tablets about two years ago, and was not prescribed any at the time of his death. She explained that she was taking Oromorph, but she was quite certain that he had not used her prescription. She stressed that she was not prescribed the sort of quantities that he was talking about.)
75. The RMN completed the man's first reception health screening during the same visit to the segregation unit. The doctor remained with her. She found him to be disruptive, aggressive and argumentative and extremely difficult to engage in conversation. However, he seemed lucid and did not seem to be hallucinating or showing signs of a mental illness, so she got what information she could from him. She noted that he had abused staff and refused all offers of medical intervention.
76. The RMN asked him if he was having any thoughts of suicide or deliberate self harm. He said that he was not. He was very angry and demanded detoxification treatment. However, she recorded that neither she nor the doctor had observed any withdrawal symptoms. She wrote that staff should continue to monitor him and complete a secondary health screening. She told the investigators that he complained of stomach cramps.

77. The man spent the night in the segregation unit, where he continued to behave anti-socially, banging pipes. He was checked once an hour by the segregation unit staff.
78. A nurse tried to review the man at about 9.20am the next morning to complete the secondary health screening. However, officers on the segregation unit advised her not to visit him because of his behaviour. She looked in the cell, which was 'a mess'. He had thrown his breakfast over his cell. He was partially clothed and told her that he had 'shit all over [his cell]' because he was unwell. She tried to talk to him through the door, but eventually decided that she could not complete an assessment.
79. The man was discussed at the daily morning healthcare handover meeting. Because of his violent behaviour towards the officers on 31 October, staff present agreed that a referral should be made for an assessment by the mental health in-reach team. The RMN was asked to make an 'urgent' referral the same day to the in-reach team, meaning that a CPN would have been required to assess him within 48 hours (in other words by Friday evening). (However, the Head of the mental health in-reach team confirmed that the team never received a referral for him.)
80. The man faced three adjudications for throwing the tray of food at an officer, trying to punch another officer and throwing his television at his cell door. At about 9.50am, the duty governor went to the segregation unit to chair the daily adjudication panel.
81. The governor looked into the man's cell through the observation panel and witnessed him shouting and making threats. He told the investigators that his behaviour was 'bizarre'. He decided to open and adjourn the adjudication process against him without involving him at that stage, to allow for further medical assessments. He was concerned about his ongoing threats to staff and his violent and unpredictable behaviour. The governor wanted him to be seen by healthcare staff before he resumed the adjudication process. He wanted to make sure that he was fit to attend a hearing and argue his case.
82. At about 10.00am, the orderly officer visited the segregation unit to switch the water back on in the man's cell. (The orderly officer is responsible for the prison regime and responds to incidents throughout the day.) The water had previously been switched off after he flooded the cell. The orderly officer did not talk to him while he did this.
83. The duty governor told segregation unit staff to ask a member of the healthcare team to check the man. A SO telephoned the RMN in the healthcare centre and asked her to come over to check him at about 10.15am. She went to the segregation unit and spoke to him. She spent about ten minutes standing in the doorway to his cell. It was still a mess. She told the investigators that he was rude and aggressive and continued to demand medication. However, she had no immediate significant concerns about him.

84. When the RMN spoke to him, he was 'responsive and lucid'. He said that he would behave if he was given diazepam and tobacco. He denied having any immediate thoughts of suicide or deliberate self harm. She arranged for a doctor to come to the unit and assess his need for detoxification. However, she wrote in the clinical record that he was still not showing any signs of drug or alcohol withdrawal. She told the investigators that she saw no signs of a mental illness.
85. The duty governor visited the man again in the segregation unit at about 11.00am. His mood was very different, and he now appeared quiet, calm and chatty. He was wearing clean clothes, had cleaned his cell and had taken a shower. The governor completed a cell sharing risk assessment (CSRA). He assessed him as high risk, meaning that he should not share a cell with another prisoner.
86. The man was then taken to the reception area to complete the reception process that should have taken place two days earlier. While there, he apologised to an officer for his behaviour on 31 October. He then returned to the segregation unit until a doctor could check him. By midday, he seemed more settled.
87. A doctor assessed the man in the segregation unit at about 3.20pm, after he finished his surgery on Houseblock 4. He was escorted and accompanied by an Integrated Drug Treatment System, or IDTS, pharmacy technician because he does not carry keys. The doctor told the investigators that, when he arrived, officers told him that he was more settled and his behaviour had improved. They asked the doctor to decide whether he was fit to move to a normal wing with other prisoners.
88. An officer accompanied the doctor and the pharmacy technician while the doctor completed his assessment in the man's cell. The doctor told the investigators that he had consulted his clinical record and was aware of his colleagues' recent entries. However, he did not know that he had brought in his own medication for alcohol dependency because this was not recorded in the clinical record. During the assessment, the doctor thought that he seemed calm and settled. The pharmacy technician also told the investigators that he was not aggressive and, instead, was laughing and joking and seemed pleased to see the doctor. She thought that he behaved appropriately and did not give cause for concern.
89. The man told the doctor that he had been misusing his partner's pain relief medication, as well as heroin and alcohol. (His partner disputes his claim about using her pain medication.) He said that he was taking heminevrin (used to treat alcohol dependence), temazepam and diazepam (both benzodiazepines). He did not complain of any withdrawal symptoms. The doctor did not think that he seemed either agitated or restless. He told the investigators that he saw no evidence that he was in distress or withdrawing. He checked for tremors, shakes, sweats and slurred speech and found no evidence of any. His pupils were mid-size.

90. The pharmacy technician similarly told the investigators that the man did not seem intoxicated and did not show any symptoms of withdrawal. She recalled that he was lucid, was not experiencing tremors and did not look waxy or clammy in appearance. His pupils were normal.
91. The man asked to be moved to normal location on a wing with other prisoners. The doctor decided that he did not require detoxification treatment and agreed that he should be moved to the first night centre on C wing on Houseblock 4 where the IDTS team are based. This unit provides monitoring for drug and alcohol withdrawal and 24 hour nursing cover. The doctor thought that this was a sensible location in case he developed withdrawal symptoms.
92. Although his primary task during the assessment was to check for withdrawal symptoms, the doctor did not think it necessary to make a further referral to the mental health team based on his observations in the segregation unit. Once again, he thought that the nurses on Houseblock 4 would be able to monitor the man for any signs of mental illness. The doctor anticipated that he would have daily interaction with the nursing staff on Houseblock 4. He did not specifically ask him about self harm or suicidal thoughts.

The move to Houseblock 4

93. An officer escorted the man from the segregation unit to Houseblock 4. He was calm and talkative during the move. A governor met them en route and had no concerns about his behaviour. The officer left him in the C wing holding room on Houseblock 4.
94. The pharmacy technician saw him again in the holding room while he waited to be allocated a cell. He was still laughing and joking and held an appropriate conversation with her. She performed a second urine test and he complied. An officer escorted him to the toilet while he provided a sample. He tested positive only for benzodiazepines. She also checked his blood pressure. He was still not showing any signs of withdrawal or intoxication. She went to the healthcare centre to show the doctor the results of the urine and blood pressure tests.
95. The duty governor had already completed a cell sharing risk assessment (CSRA). Because of the man's violent and unpredictable behaviour, he had assessed him as presenting a high risk of harm to other prisoners. He was allocated cell six on the third landing of C wing. He was the sole occupier of a double occupancy cell.
96. When the man went to collect his dinner at about 4.00pm, he assaulted two prisoners (both prisoners of black and minority ethnic, BME, origin), throwing his tea tray at them. There were about 20 prisoners in the meal queue at the time. A prisoner who has since moved to another prison told the NOMS internal investigation team that the two other prisoners provoked him and he then retaliated.

97. An officer was working on the first landing of C wing during the mealtime. He did not witness the incident but heard a noise and shouts coming from the servery area. He went to investigate and saw one of the prisoners who had been assaulted. His face was covered in food. The other prisoner also had some residue on his face and his eyes were burning from contact with the food. There were plates and trays on the floor. One of the prisoners who the man assaulted asked the officer, 'Why did he do it? I've never met him before'.
98. The man was continuing to behave in a loud and aggressive manner. An officer made notes about the incident. Another officer told him to go to his cell. Both officers walked him back to the third landing. He went of his own accord and did not resist. One officer asked him why he assaulted the other men. He replied, 'Because I hate fucking niggers'. At about 4.05pm, the officers locked him in his cell because they were concerned that he might display racist attitudes to other prisoners during the association period. He seemed to have calmed down when the officers left him in the cell.

Barricading

99. Both officers returned to the servery to supervise the other prisoners. Meanwhile, two other officers were working on the third landing and went to the man's cell to check him. At about 4.10pm, they looked through the observation hatch and saw that he had now barricaded himself into the cell. He had wedged a wooden locker and wooden chair between the door and the bed. They called another officer up to the third landing. He also checked him through the observation panel and decided that a SO (the manager responsible for the regime on Houseblock 4) should be informed.
100. The SO had not yet met the man and was not involved in his move from the segregation unit. He was talking to a governor in his office on the second landing of Houseblock 4 when the officer interrupted their meeting to say that they had locked him in his cell after he assaulted two BME prisoners. The SO and governor agreed that this had been the right decision. The governor informed the SO that his behaviour had been problematic since his arrival and that he had spent time in the segregation unit. By 4.15pm, he had managed to barricade himself in his cell.
101. While the governor left to go to Houseblock 7, the SO immediately went to C wing where he met an officer. The officer informed him that the man had now barricaded himself in. The SO went firstly to check on one of the victims of the assault. However, within seconds of arriving at the victim's cell, he heard the sound of breaking glass coming from his cell.
102. At about 4.20pm, the SO and officer went to speak to the man through the observation panel. He was sitting smoking a cigarette on his bed with his legs crossed and seemed calm. The locker was still on its side between the door and the bed. There was a wooden chair on top of the locker. The SO asked him to remove the barricade. He did not acknowledge the request and

instead shrugged. The SO made the same request for a second time but again got no reply.

103. The SO shut the observation panel. He and the officer walked away from the cell, heading to the centre office on the second landing to contact the orderly officer for advice. However, they had only walked a few paces when they heard a loud bang and returned to the cell. They looked inside and saw the man standing in front of the door with a television raised above his head. He screamed a threat at them. The two men quickly shut the observation hatch because they thought that he was about to throw the television at the door.
104. After they heard another bang, the SO opened the observation panel again. He saw the man repeatedly bringing down the television on the corner of his bed. The screen shattered and the innards of the television were exposed. He snarled and made a verbal threat to any staff who tried to gain access to the cell. The officer told the investigators that his face was contorted with rage and he was almost incoherent. The SO closed the observation panel because he thought that he was about to attack it with shards of broken glass from the television, which he was holding in his hands.
105. They went down from the third landing to the centre office on the second landing. At about 4.25pm, the SO made a telephone call to the orderly office to speak to the duty governor. The man was left unobserved in his cell. After the SO told the governor that he had barricaded himself into his cell, the governor told the orderly officer (who was in the orderly office with him) to arrange a planned removal using force once all of the other prisoners had collected their tea and been locked in their cells.
106. The governor and SO agreed that staffing levels would not allow them to safely manage the evening mealtime and simultaneously remove the man from his cell. Mealtime was already underway and there were 180 prisoners on Houseblock 4. The managers agreed that, for the time being, he was contained in his cell. All of his previous behaviour had consisted of threats and harm directed at others. He had not tried to harm himself and was threatening staff with the shards of the television screen.
107. The governor asked the SO if any of his staff were willing to give up their tea break in order to don control and restraint clothing and remove the man from the cell. An officer and another officer from Houseblock 4 agreed to assist. The orderly officer contacted a Physical Education Senior Officer (PESO) in the gym, who agreed to provide two other officers. In addition to these four officers, she arranged for the planned removal to be recorded by an officer with a video camera in accordance with policy.
108. The orderly officer sent a Principal Officer (PO) to Houseblock 4 to assess the barricade because he was in the middle of checking the 4.30pm roll count. She also planned to switch the water off in the man's cell because he had previously flooded his cell in the segregation unit. The governor asked for healthcare staff to assess the two prisoners who the man had assaulted.

Cell fire

109. The man then set fire to a television, clothes, a chair, a mattress and a wooden cabinet directly behind his cell door. He did not press his cell bell or shout for help either before or during the fire. CPIG inspectors have found that he used the cigarette lighter he had been given by staff to start the fire.
110. The SO was still on the telephone to the duty governor when he heard somebody shout 'Fire!' He told the investigators that he did not know whether this was a prisoner or an officer. Only about a minute had passed since the he had left the man's cell. An officer reflected during interview that a prisoner most likely shouted to raise the alarm because there were no officers on the third landing at the time.
111. The SO left the centre office and ran up to the third landing. He instantly saw thick black smoke billowing out under the man's cell door and down the wing. At 4.30pm, one of the staff pressed the general alarm rather than the fire alarm. (It is not clear from the evidence which member of staff pressed the alarm. The nearest fire alarm call point on the third landing of C wing is located at the far end beyond the cell. The general alarm is only meant to be used to summon staff if there is a disturbance or fight on the wing.)
112. An officer shouted to raise the alarm. He approached the man's cell, but was beaten back by the smoke. He rolled out the fire hose from its reel near the centre of Houseblock 4 to the end of the landing close to the cell. He left it there and retreated because he was not wearing any protective clothing. The smoke was spreading very quickly. The SO approached the cell but was also beaten back by the intensity of the smoke.
113. Before the fire started, the officer had returned to the servery to oversee the mealtime prior to beginning the man's planned removal from his cell. When the alarm was raised, he went directly to the third landing and tried to approach the cell but was also beaten back by the smoke and heat. He ran to D spur on Houseblock 4 to collect cell snatch rescue equipment (CSRE) smoke hoods. (There were two of these hoods stored on each houseblock at the time of the cell fire. Each smoke hood lasts for a maximum of 15 minutes during a fire before its usefulness expires.) He took one and another officer took the other.
114. The duty governor, the orderly officer and another governor were en route to Houseblock 4 in response to the general alarm when the fire alarm sounded at about 4.32pm. This was activated automatically because smoke had spilled out of the cell through gaps in the doorframe and risen to hit the beam detector on the third landing of C wing. (Beam detectors are smoke detection systems used in wide, open areas like a prison landing.)
115. The activation of the fire alarm caused vents in the roof of the wing to automatically open. However, instead of allowing smoke to disperse from the wing as intended, the smoke gathered and spread to the other landings. The

in-cell smoke detection system in the man's cell only activated a short while later.

116. The orderly officer arrived on C wing, reached the second landing and saw the smoke coming from the third landing. He identified the cell and used his radio to tell control room staff to call the fire service. They telephoned the fire service at 4.35pm and then requested an ambulance separately at 4.40pm.
117. Officer A returned to C wing with a smoke hood. However, the orderly officer then asked him and three other officers to go to the segregation unit to put on control and restraint clothing and prepare for the use of force. He anticipated that the man might resist once staff were in a position to remove him from the cell.
118. The SO briefed the orderly officer. The orderly officer then instructed staff to use the CSRE to tackle the fire and asked colleagues to fetch additional smoke hoods. He also contacted the communications room on the radio to instruct the gym staff to prepare for the arrival of the evacuated prisoners. (The local fire safety policy identifies the gym as the evacuation point in the event of a cell fire on a houseblock.)
119. The duty governor ordered the SO to unlock and evacuate all 48 C wing prisoners to the gym. As they unlocked each door, the officers shot the bolts to ensure that prisoners could not be locked or trapped in their cells. Most of the prisoners had already been locked up after collecting their tea and needed to be unlocked. Only one prisoner pressed his cell bell during the emergency.
120. The evacuation of C wing began at 4.38pm and was successfully completed at about 4.43pm. The third landing was evacuated, followed swiftly by the second and then the first. The SO accounted for every prisoner. The prisoners cooperated fully. Staff lined the route from Houseblock 4 to the gym. The orderly officer assisted with the evacuation and went to the gym to check the prisoners. Another SO remained in the gym with the prisoners.
121. Six members of staff were ultimately responsible for tackling the fire and bringing the man out of his cell. They were the first members of staff trained in the use of CSRE to reach the scene. They began tackling the fire at the cell door at 4.35pm.
122. Officer B put on the smoke hood that Officer A had collected and went to the man's cell. He was the first member of staff to go to the cell wearing CSRE.
123. Officer C responded to the general alarm. He was working on Houseblock 2 at the time and made his way to Houseblock 4. He approached the cell but retreated after being overwhelmed by smoke. He donned a smoke hood which had been left on the landing by a colleague.
124. A PESO also responded to the general alarm. He was en route to Houseblock 4 when the fire alarm sounded. He reached C wing as the prisoners were being evacuated. He met both officers at the scene and

checked the seals on their smoke hoods. So far, only two smoke hoods had been brought to the scene so the PESO could not yet wear one.

125. Both officers approached the cell door wearing their smoke hoods. It was red hot. Under the direction of the PESO, the officers used the hose to pump water through the gaps between the door and the doorframe and cool the door. Officer B had already collected the key to remove the inundation plug. (This is a circular piece of metal located in the inundation port in the middle of every cell door. It can be unscrewed and removed to allow access for a hose.) He tried twice to unscrew the inundation plug using the appropriate tool but it had seized and was stuck fast. Officer C also tried to remove it but was unsuccessful.
126. Officer D arrived on C wing, saw the fire and returned to Houseblock 7 to collect two additional smoke hoods. Officer E had been working with Officer C on Houseblock 2. When the general alarm sounded, he had left to investigate and she had initially remained on Houseblock 2. However, when the fire alarm subsequently sounded she realised that Officer C would not have taken smoke hoods with him, so she collected two smoke hoods and took them to Houseblock 4.
127. When Officer E arrived, she put a smoke hood on. As she approached the man's cell, Officers B and C were trying to remove the inundation plug, but it still would not budge. The PESO told the investigators that he had not yet been given a smoke hood at this stage, but nonetheless used his baton and the hose nozzle to smash the glass in the cell door observation panel. He estimated during interview that it took him about six attempts to do this. Because the smoke hoods inhibited communication and the thick black smoke inhibited vision, some of his colleagues backed away when they saw him raise his baton, fearing that the man was emerging from the cell and might assault them. The officers then inserted the nozzle through the broken observation panel to pump water into the cell. The process of trying to remove the inundation plug, ultimately smashing the glass and flooding the cell lasted from 4.36pm until 4.43pm.
128. Officer D then arrived with two smoke hoods. He put one on and the PESO was pulled away from the cell door to put the other one on. Although staff continued to inundate the cell, smoke kept pouring out. They decided to push the cell door inwards at about 4.43pm. A DPSM told his officers to expect resistance and ordered them to draw their batons because the man had already erected a barricade, destroyed property and made threats. The officers tried to push the door open but it only gave about six or eight inches because of the barricade. The staff continued to inundate the cell with the hose through this gap.
129. Once the officers saw the amount of dense black smoke coming through the gap in the door and felt the 'unbearable' heat, they reholstered their batons. They realised that the man would be unconscious and no longer represented a threat to them. He had not shouted for help during the rescue operation. The officers pushed against the cell door for several minutes but eventually

stopped because they were concerned that he might be lying behind it and might be further injured if they continued to push.

130. Other officers had all gone to the segregation unit to put on control and restraint clothing. They then sprinted back to Houseblock 4. However, they were told to stand down when it became clear that the man would not be conscious when he was removed from the cell.
131. At the cell door, the PESO and Officer C both requested the anti-barricade allen key. (The allen key is used to remove the anti-barricade stop. This is a device positioned on the door frame of each cell by the lock, intended to keep officers safe by preventing cell doors from opening outwards onto the landing.) The barricade was preventing the officers from pushing the cell door inwards, so they planned to remove the anti-barricade stop in order to pull the door outwards. Officer C also requested a torch and a door jack.
132. While the officers tried to gain entry to the cell, Officer E acted as a point of contact between them and the managers at the end of the landing. She requested the anti-barricade allen key and torch from a governor. Officers E and C and the PESO all told the investigators that they found this process frustrating because it seemed to take a long time for their colleagues to locate the requested items for them. Officer C felt very frustrated. In the smoke and confusion, he did not think anybody had heard him and removed his smoke hood to shout instructions. The area around the cell remained pitch black. Officer D felt helpless. She cleared the landing of empty smoke hood packs and asked for fresh smoke hoods.
133. The cleaning officer carried the padlock key for the cabinet in the SO's office which contained the anti-barricade allen key. It became apparent that he had left Houseblock 4 to evacuate prisoners to the gym. The orderly officer sent an officer to the gym to collect the padlock key. As a precautionary measure, he also sent another colleague to Houseblock 1, where he knew there was another allen key. (There was actually another allen key in a drawer on Houseblock 4, but none of the staff present during the emergency realised this.) The orderly officer radioed for the fire service again and was told that they had arrived and were parking in the exercise yard. Fire fighters arrived at the prison gate at 4.43pm. However, they did not reach the wing for a further ten minutes. They later described a slow procession through the prison, hindered by staff stopping to unlock and then lock each gate in turn.
134. Once the padlock key was retrieved from the cleaning officer, an officer opened the cabinet in the SO's office, located the anti-barricade allen key and gave it to the governor. She gave it to Officer E, who took it to the officers at the cell. A PO sent officers to the orderly office to fetch working torches, but these did not arrive before the man was pulled out of the cell.
135. At 4.51pm, the PESO used the allen key to remove the anti-barricade stop. The cell door remained red hot. The officers were now able to pull the door outwards. Contrary to fire safety training, which advises staff to stay low and

behind the door as they open it outwards, some of the staff were in front of the door when they pulled it fully open.

136. However, the officers did not encounter a backdraft because the door had already been ajar for some minutes and the cell had already been inundated. Thick black smoke billowed out but no flames. Before entering the cell, the officers sprayed more water from the hose and removed debris from the doorway.
137. As they entered the cell, the officers held onto each other's belts because they could see nothing through the smoke. The PESO led the way, with Officer D following. Officer C entered third, holding Officer D's belt. Officer C proceeded even though the flashing light in his smoke hood indicated that its period of usefulness (15 minutes) had expired and he should withdraw from the area.
138. Officer B was able to put on a fresh smoke hood before entering the cell. Following Officer E's requests, only one additional hood had been brought to the cell, so Officer C could not do the same. Officer D saw that Officers B and C's hoods had expired and felt frustrated that there was only one fresh hood. The houseblock torch did not work, but Officer D later reflected that the smoke was probably too thick for it to have been of help in any case.
139. While the four officers entered the cell, the DPSM held onto the last officer's belt and remained in the doorway. The officers passed out a chair and cabinet in order to clear a path and reduce the amount of potential kindling. A nurse assisted the officers, holding the cell door open and moving furniture out of the way. The officers conducted a methodical search in the pitch black, moving their hands high and low in the cell hoping to make contact with the man. They moved by touch alone. Officer C told the investigators that he felt extremely disoriented. He recalled that the doorway started to diminish to a tiny speck of light.
140. Within a minute, Officers D and B located the man under the sink in the toilet area in the far left hand corner of the cell. The officers turned him over before dragging him out feet first onto the landing at 4.53pm. They laid him down about six feet from the cell.
141. Two doctors, a Sister and a nurse were waiting to treat the man when he was brought out of the cell. The Sister and the nurse were both wearing smoke hoods. He had no pulse and was not breathing. By now, the smoke had mostly dissipated on the landing and it was sufficiently safe for the nurses and officers to remove their smoke hoods.
142. Officer B used a bowl of water to clean the man's face. Staff began performing cardiopulmonary resuscitation (CPR). Officer C (a qualified first aider) gave mouth-to-mouth breaths. The Sister and nurse took turns to perform chest compressions. The PESO counted the compressions to help the nurses.

143. Members of the fire service arrived on the wing just after staff began trying to resuscitate the man. The nurse took turns with a fire fighter giving breaths using a bag and mask. The Sister used a suction machine to remove vomit from the man's airway. The nurses attached a defibrillator to him. (This is a portable machine which can deliver an electric shock to reset a patient's heart rhythm if one is found.) However, the machine indicated that he should not be given an electric shock because a heart rhythm could not be found.
144. While the officers were rescuing the man, the duty governor left C wing with senior colleagues to coordinate the emergency response. He opened the command suite at 4.48pm. Another governor had then taken charge at the scene. An Acting Governor and an Acting Deputy Governor were en route to the orderly room when they were met by the duty governor and went directly to the command suite.
145. The paramedics arrived at the prison at 4.51pm and reached the wing a few minutes later after the man had been brought onto the landing. The fire had been completely extinguished in the cell by 5.00pm. The paramedics gave him an injection of adrenaline and continued CPR. They found a pulse. Another ambulance crew arrived at 5.18pm. He was taken on a stretcher to the ambulance, which left the prison at 5.38pm. He was taken to hospital, accompanied by three officers. He was not handcuffed during the journey because of his injuries, even though he was assessed as a high risk to the public.
146. The man had not nominated a next of kin during the reception process. He had not made any telephone calls during the previous 48 hours. At 5.40pm, an officer located contact details for his mother. She rang the telephone number provided and spoke instead to his partner. She explained on the telephone that she could only speak to his mother. Although his partner then said that she would ask his mother to call back, this did not happen.
147. The officer was unhappy disclosing information to anybody other than the next of kin, so she consulted the Acting Governor and they agreed that the police should visit the man's mother in person to tell her that her son was in hospital. At about 6.30pm, the Acting Deputy Governor contacted the police and asked them to visit his mother. A family liaison officer was appointed.
148. The clinical lead at Holme House arranged for the officers and the PESO to be taken to hospital to be treated for smoke inhalation. At 5.55pm, the five staff travelled to hospital with a SO from the care team. They were given oxygen and had their blood tested and chests x-rayed.
149. The prisoners who had been evacuated to the gym were taken back to their cells on C wing by 6.15pm. The association period took place in order to restore the normal running of the prison and allow prisoners time to discuss the events of the day.
150. The Acting Governor Graham held a ten minute hot debrief meeting for staff at 7.25pm. (The hot debrief allows staff involved in the emergency to discuss

how they are feeling and learn any immediate lessons from the incident.) Staff reviewed all prisoners subject to self harm monitoring. Ten of the 19 smoke hoods kept at Holme House had been used during the emergency. The orderly officer arranged for the remaining nine to be gathered and one was put on each houseblock in case of a further fire that night.

151. The man was placed on a ventilator in the intensive care unit at the hospital. He had suffered very serious smoke inhalation. At 7.35pm, hospital staff informed the escort officers that he would not recover. His partner arrived and spent the night at the hospital with him.
152. By 8.15pm, the escort at hospital was reduced to two officers on the advice of the prison's Head of Security. Staff were instructed to attach the escort chain only if the man regained consciousness. Two officers stayed with him at the hospital overnight.
153. At 7.30am the next morning, two other officers took over the hospital escort. The duty governor asked the staff who tackled the cell fire to come into the prison at 9.00am to complete a written statement about the incident. He arranged for them to take immediate leave and not return to work until after the weekend. He gave the officers his personal mobile number and made sure they understood that the care team was at their disposal.
154. The family liaison officer and a governor visited the hospital. In the presence of seven family members, including the man's mother, the hospital staff performed a brain stem test at 2.20pm. He was declared dead at 2.35pm.
155. The family liaison officer spoke to the family after he died. He expressed the condolences of Holme House staff and explained that the prison would contribute towards the funeral expenses. The family agreed to the prison sending a floral tribute to the funeral and to the family liaison officer and the Acting Governor attending the funeral.
156. The post mortem report showed that the man died as a result of smoke inhalation. The carbon monoxide levels in his blood were extremely high. He had undiagnosed lung cancer and tuberculosis.

ISSUES

Clinical care

157. The man's behaviour was erratic and unpredictable between 31 October and 2 November. Staff told the investigators that his mood could change within minutes from extreme aggression to amiable conversation. However, some patterns can be identified. He repeatedly destroyed property (including two televisions) on consecutive days. He tried to throw his dinner over an officer when he arrived and two days later he again threw his evening meal over two prisoners.
158. An analysis of the man's toxicology results was completed for the Forensic Science Service. No evidence was found that he was intoxicated with alcohol prior to the cell fire, but that alcohol might have left his system during the 24 hours he was in the hospital before he died. Low doses of diazepam (used to treat alcoholism), chlordiazepoxide (used to treat alcohol withdrawal), mirtazapine (antidepressant) and citalopram (antidepressant) was found in his blood, the amounts consistent with prescription medication taken before he arrived in prison. It was not thought that any of these drugs contributed to his death. It concluded that he would not have been under the influence of amphetamines, cocaine, ecstasy or opiates at the time of the cell fire.
159. It remains unclear why the man's behaviour was so erratic and volatile. We do not know whether he was under the influence of alcohol, drugs or neither when he entered Holme House. A SO told the investigators that he seemed to be drunk in the reception area but later on 31 October, the doctor thought that he was drowsy and probably under the influence of an opiate or a sedative. She decided that he should be monitored and that it was inadvisable to prescribe any withdrawal medication. She told the investigators:
- '...it would have been dangerous and foolhardy to prescribe [the man] anything, given that he appeared to have some kind of medication or drug in his system and he was settled and quite comfortable...'
- 'It's very difficult under those circumstances to say whether there's an underlying mental health problem or whether the behaviour is just a consequence of whatever substance they have in their system. So often it's just a matter of kind of waiting...'
- 'We wouldn't necessarily do a mental health referral in the first instance, because again it's very difficult for mental health to do an assessment if someone's under the influence, both in prison and in the community. So often we would wait a few days to see how things were going and if their behaviour remained erratic or there were concerns, then obviously we would ask mental health for an assessment.'
160. Another doctor found no evidence that the man was withdrawing from drugs or alcohol when he assessed him on 1 November. He recorded that he was

talking coherently. On 2 November, when another doctor assessed him before he moved to Houseblock 4, his mood was settled and he cooperated. The doctor told our investigators:

‘Well he didn’t complain of any symptoms of withdrawal. He was calm, he was settled, there was no evidence of any sort of agitation or restlessness... his physical presentation would suggest that there were no observed signs of any sort of distress or withdrawal. There were no shakes, there were no tremors, there were no sweats, his speech was normal and he was really quite settled and calm during the whole of the assessment process.’

161. The man was assessed by three different doctors on the Monday, Tuesday and Wednesday, as well as several nurses, and none of them identified withdrawal symptoms. Consequently, they did not prescribe any medication between his admission to prison and the cell fire.

162. He arrived at Holme House with vitamin B and thiamine. These medications (used to treat alcohol dependency rather than alcohol withdrawal symptoms) were taken to the pharmacy. Ultimately, the original medication would have been destroyed and a new identical prescription would have been issued if this was deemed appropriate by a doctor. However, none of the clinical staff who assessed him thought that he required medication. An investigator and the clinical reviewer who completed a review of the clinical care he received, commented:

‘Assessment and care planning, including the monitoring of the man’s health status and signs and symptoms of alcohol withdrawal, and the treatment he was given, were appropriate. Healthcare staff tried to intervene but he was unwilling to cooperate with a proper clinical assessment, and for much of the time he did not present as suffering from acute alcohol withdrawal symptoms requiring medication. From reviewing the clinical record and from the interviews it was likely that he was actually still intoxicated during this time making further clinical assessment and prescription of treatment either difficult at the very least or not possible. Clinical intervention from healthcare staff was clearly guided and limited due to his intoxicated state, and in any event healthcare staff’s observations suggested that he was not showing any acute signs of alcohol withdrawal.’

163. Although the Sister is not a member of the mental health in-reach team, she checked the man’s state of mind on 1 and 2 November. She asked him if he was thinking of harming himself and he said that he was not having any suicidal thoughts. She was asked to make an ‘urgent’ referral to the mental health in-reach team on the morning of 2 November after his behaviour was discussed at the daily healthcare handover meeting. Although a referral was not received by the team before he died, an urgent referral requires a formal assessment by a mental health nurse within 48 hours. He was therefore supposed to have been assessed before Friday lunchtime at the latest. This was a sensible precaution because his erratic behaviour required explanation.

The investigator and clinical reviewer made the following observations about the man's mental health:

'The clinical reviewers ascertain from reviewing the clinical record and reading the interview transcripts that on initial reception screening and subsequent assessment there was no specific evidence identified by healthcare staff of any psychotic phenomena or indeed any other psychiatric signs and symptoms such as altered perception (auditory or tactile hallucinations), delusional beliefs or ideas of reference or paranoia.'

164. They do not make any recommendations as a result of the clinical care the man was offered. They conclude their review with these comments:

'Healthcare staff acted professionally and the interventions they carried out were appropriate and timely. He clearly presented as challenging to both prison and Healthcare staff in their efforts to manage his behavioural disturbances and his clinical presentation. Healthcare staff tried their best to engage with him to attempt a level of more in-depth clinical assessment and clinical intervention, but regrettably he was either unable or unwilling to cooperate with staff. Under these extenuating difficult circumstances the clinical reviewers' opinion is that he received care to an equivalent standard had he been in the community as opposed to in custody.'

The possibility that the man intended to harm himself

165. Until he lit the cell fire, the man had not tried to harm himself between 31 October and 2 November. All of his aggression seemed to be directed externally towards staff, other prisoners and property. He did not tell staff that he was thinking of taking his own life. We therefore think it was reasonable that staff did not begin Assessment Care in Custody and Teamwork (ACCT) self harm monitoring between 31 October and 2 November. His partner told the family liaison officer that she did not think that he meant to take his own life when he set the cell fire, but was rather behaving antagonistically to aggravate the staff.
166. It is impossible to know why he started the fire in his cell and whether he anticipated how quickly it would get out of control. He had no previous convictions for arson. He reported that he had taken large quantities of drugs and alcohol before he was arrested, but the toxicology report does not confirm this assertion. His behaviour frequently seemed to escalate quickly from compliance to hostility and it seems possible that the decision to start a fire was an entirely impulsive act of hostility that got out of hand. He had committed similar rash and destructive acts in the previous 48 hours, such as smashing property and flooding his cell.
167. It is concerning that the man did not shout for help or press his cell bell when the fire started. However, given the rapidity with which the fire took hold and

the sheer volume of thick black smoke pouring onto the landing, it seems quite possible that he was almost immediately overcome.

Location

168. We are satisfied that healthcare staff closely and regularly monitored the man's behaviour and mood from his arrival until the afternoon he set the fire. He completed urine tests on 31 October and 2 November. We believe that he was sensibly and appropriately located, initially in the healthcare centre after the Sister and doctor intervened to prevent a stay in the segregation unit on his first night. After his behaviour deteriorated the next day, staff moved him to the segregation unit. The necessary algorithm was completed and more staff checked him. The following day, a doctor and pharmacy technician both thought he would benefit from moving to the first night centre, which has 24 hour nursing. This was a sensible decision because IDTS healthcare staff were present if he started experiencing withdrawal symptoms.

Use of force

169. The investigators spoke to the SO, who managed the use of force in the reception area on 31 October after the man assaulted staff and spread shower gel on the floor of the holding room. We consider that the use of force was proportionate and necessary on this occasion to keep him safe and protect the officers, two of whom he had already attacked. His behaviour was unpredictable and volatile and had started to endanger other prisoners as well. After he was moved to the segregation unit, all of the officers involved appropriately documented their actions on 'Use of force' forms.
170. During interview, the SO singled out an officer for praise, remarking that he stayed calm despite being assaulted and was not provoked by the man's antagonistic behaviour. We trust that the Governor will take note of the SO's comments.

Barricading

171. Prison Service Order (PSO) 1400 concerns incident management. It is a restricted document, but the investigator obtained permission to reproduce part of it in this report. The PSO instructs staff how to proceed in the event of a prisoner barricading himself in his cell. The directions principally apply to hostage taking, but the guidance still applies to the kind of situation which unfolded on 2 November just before the fire. The PSO offers the following guidance for the first on scene:

'Remain at the site until a trained negotiator sent by the Incident Commander relieves you. This may be some time. **Do not attempt to engage the perpetrator in any dialogue.**

'Reassure the perpetrator that a message has been passed on and that an appropriate member of staff will come to talk with him shortly.

Listen to and try to remember the requests made and what the perpetrator is saying.

'Beware of antagonising the perpetrator. Talk only when necessary, remain calm, and **do not make any promises or concessions**. Stick to the line that someone will be along to talk to him soon.'

[Bold text in the original]

172. A SO and Officer A left the man alone after he barricaded himself in his cell. They went to telephone the duty governor to seek advice. As a result, he was not being observed or monitored when he started the fire in his cell. The advice in the PSO says that a member of staff should remain at the cell in this type of situation.
173. However, the man had smashed a television and had used shards from the glass screen to threaten staff. He also made a direct verbal threat to them. We think it was entirely reasonable that the SO and officer shut the observation panel for their own safety.
174. The investigators asked the SO about his actions just prior to the cell fire. He agreed that he should ideally have left Officer A at the man's cell door to monitor his behaviour while he (the SO) made the telephone call to the orderly office.
175. However, the SO told the investigators that, with limited staff available, his initial priority was to use all available officers to ensure that the remaining prisoners collected their meals and returned to their cells. He and the duty governor intended that staff would use force to remove the man from his cell during the tea time lock up.
176. The man's behaviour prior to the cell fire consisted of aggression towards staff, prisoners and property. He had not voiced any suicidal thoughts. He had just carried out a suspected racially motivated attack on other prisoners. We therefore think that it was a reasonable course of action to contain him by locking him in his cell.
177. Although staff could not reasonably have expected the man to then start a fire, it was entirely likely that he would carry out another destructive act, such as flooding his cell. If the SO had asked Officer A to remain outside the cell in accordance with the PSO's instructions, the officer would not have been able to see what he was doing because the observation panel was rightly closed. However, we think that he would have observed the first signs of smoke seeping out from under the door onto the landing. This would have allowed him to promptly activate the fire alarm a very short distance away, which would have prevented the erroneous activation of the general alarm.
178. The officer could also have radioed the control room immediately with precise information about the barricade and the location of the fire. In turn, staff on the other houseblocks would then have known about the barricade and the

fire from the outset and would have been able to bring the anti-barricade allen key and smoke hoods to the scene without delay. In short, the subsequent emergency response might have been better coordinated and it would, in all likelihood, not have taken 23 minutes to rescue him.

179. On balance, we think that, even had an officer been left to monitor the cell, the man would still have been rapidly overwhelmed by the sheer volume of thick black smoke in his cell. Staff would still have had to pump water into the cell, and deal with the faulty inundation port. They would then have had to negotiate the barricade and locate him. We consider that this would still have taken a substantial amount of time, and he would, on balance, already have inhaled a fatal amount of smoke. We make the following recommendation:

The Governor should ensure that all staff understand the instructions in Prison Service Order 1400 and take appropriate action when a prisoner erects a barricade in their cell.

The cell fire

180. CPIG inspectors advised the investigators that the first five minutes after a fire starts in a confined space like a cell are critical. Research by the Building Research Establishment commissioned by the Prison Service in 2005 demonstrated that a prisoner trapped in a cell fire is much more likely to survive if they are rescued during this period. It took 23 minutes for the man to be removed from the cell and he did not survive.
181. There were a number of reasons for the delay. Staff were not alerted to the fire at the earliest possible stage because the in-cell smoke detection system did not operate; staff were delayed in tackling the fire because the inundation port in the cell door seized; the vents in the roof did not channel smoke out of the wing as they were supposed to. As a result, prison officers were unable to work effectively, due to thick toxic smoke around the cell door. They also had to remain in the immediate vicinity of the cell for longer than the CSRE smoke hoods were able to protect them. Additionally, the anti-barricade allen key could not be located immediately to allow the door to be opened and the man's barricade to be circumvented. Without these problems, prison officers might have been able to reach him more quickly.
182. The investigators were left under no illusion about the impact that the fire had had on the officers involved. Officer E described the smoke as a 'thick, black, aggressive soup'. In spite of the 'angry' smoke, she also described the scene as 'quiet and surreal'. All of the officers agreed that events unfolded with terrifying speed. The orderly officer said that the way in which the smoke billowed down the landing so rapidly reminded him of scenes during '9/11'. The spread of smoke was faster than any of the interviewees had previously witnessed during other, smaller cell fires. The loss of any visibility near the cell shocked the officers.
183. We go on to discuss a number of systemic failings in the fire safety systems at Holme House. We have no doubt that CPIG will highlight similar failings when

they submit their findings. We make some recommendations to the Chief Executive Officer of NOMS rather than the Governor about important changes that need to be made. There are significant potential cost implications for Holme House and there may well be lessons which need to be learnt across the prison estate, particularly at those establishments built to the same specification as Holme House.

Notifying the National Head of Fire Safety at NOMS

184. We were concerned to learn that cell fires are not directly reported to the Head of Fire Safety at NOMS. We think that this should happen as a matter of routine. Additionally, we understand from the CPIG inspectors that the internal NOMS investigation has still not been shared with either them or NOMS own Head of Fire Safety. We make the following recommendation:

The Chief Executive Officer of NOMS should ensure that the Head of Fire Safety is informed of all cell fires.

Existing local fire safety policy

185. On 18 May 2011, Holme House published a local policy (safe system of work) instructing staff how to deal with a cell fire and use CSRE. The policy advises that officers must not put their lives in danger by entering a cell during a fire. Initially, they should raise the alarm by breaking the glass on the nearest fire alarm call point. This in turn activates the automatic smoke extraction system in the roof and releases the hold back devices on some doors.
186. Officers should then contact control room staff using either radio or telephone to inform them of the location of the fire. They should close all fire doors to stop smoke spreading. The first member of staff on scene should run out the hose from the reel at the centre of the houseblock, find the inundation port key and place the key and the hose nozzle as near to the cell door as possible but far enough away from the smoke. They should also fetch the CSRE smoke hoods and gauntlets stored on each houseblock for trained staff to wear.
187. Staff should check the expiry date on the smoke hood and that the security seal around the shoulders and neck is intact and is not compromised by hair or clothing. Officers should check each other to make sure they are all ready to tackle the fire. During use, staff need to monitor the indicator which will tell them when the hood is no longer effective. Smoke hoods are only effective for 15 minutes. After ten minutes an intermittent light starts flashing to tell the user that they should prepare to evacuate the area.
188. Once staff have donned smoke hoods and gauntlets, they should remove the inundation port from the middle of the cell door using the key. They must shout to the prisoner inside to either lie on the floor or move to the window. They then insert the hose nozzle through the inundation port and turn on the hose, directing the water towards the ceiling.

189. The local policy acknowledges that the inundation port may seize up. If this happens, staff are supposed to use a hammer to smash the glass observation panel. They should wear goggles for this procedure. After using the hose, officers must be satisfied that the fire has been completely extinguished before entering the cell. In the meantime, other staff should evacuate the remaining prisoners from the wing.

Additional local fire safety policy concerning non-compliant prisoners

190. On 21 March 2011, Holme House also published a local policy (safe system of work) for the removal of non-compliant prisoners from a cell after a fire. Staff are supposed initially to respond as they would to a normal cell fire, by raising the alarm, putting on smoke hoods and inundating the cell with water from a hose.
191. However, none of the staff wearing smoke hoods are supposed to try to remove the prisoner from the cell. Instead, the duty manager must take control of the emergency and request two control and restraint teams dressed in personal protective equipment (PPE) and carrying batons. These teams should arrive and remain at a safe distance from the cell and any smoke.
192. The cells neighbouring and above and below the fire should be evacuated. Staff wearing the smoke hoods must then approach the cell with a control and restraint team, who should remain far enough away to avoid inhaling smoke. Staff wearing the hoods should remove the anti-barricade stop and pull the cell door outwards, using it as a shield. The staff in hoods will then withdraw to a safe distance behind the control and restraint team.
193. The control and restraint team should then allow smoke to vent from the cell and should ask the prisoner to come out. If the prisoner does not comply or emerge from the cell, the control and restraint team should wait for the fire service to arrive and deem the cell sufficiently clear of smoke before then entering to remove the prisoner.
194. CSRE trained members of staff reached the wing and donned smoke hoods to try to remove the man from the cell. They were not assigned the task but took it on without question because they were confronted with the fire and knew that a prisoner was inside. We consider that these six members of staff went above and beyond the requirements of the local policy to retrieve him as soon as was possible from his cell.
195. With little regard for their own safety, the officers stayed at the cell door until it was opened and then four of them entered the cell. The smoke was thick and the officers could see nothing. They were forced to remove their smoke hoods to communicate, risking smoke inhalation (something we go on to address later in this report). They entered the cell despite the man's earlier threats, although they rightly concluded that he would have lost consciousness.

196. We commend the actions of the six staff who tackled the cell fire, even though it was not possible to avert a fatality. It is not often that an investigation highlights true acts of bravery and heroism. Nonetheless, heroism is the right word to use on this occasion. We hope that the Chief Executive of NOMS finds a suitable way to commend these staff.

In-cell smoke detection system

197. The existing smoke detection system in the cells at Holme House consists of ducts from six adjoining cells leading to a shared detector. This is a design shared by Holme House and other prisons built to the same specification. The fire systems at Holme House had been tested and the relevant certificates were current at the time the man died. However, doubts had been expressed about the efficacy of the system.
198. The most recent fire risk assessment for Houseblock 4 was completed in August 2010 by Holme House's full time fire safety advisor shortly after he took up the role. His assessment was reviewed again in September 2011. He made the following comments about in-cell smoke detection in his original assessment:

'In-cell detection [is] not adequate - a bid has been put in so better in-cell detection to be fitted in the houseblock.'

199. This work was described as 'ongoing' and was recorded as the responsibility of the works department. During the cell fire on 2 November, the in-cell smoke detection system did indeed prove to be inadequate. It only worked *after* the smoke had already spread from the cell to the landing and triggered the infrared detection beam in the roof.
200. CPIG inspectors comment in their Fire Fatality Incident Report:

'The cell was provided with in-ductwork automatic fire detection. This is not a recognised method of providing an adequate fire alarm where people may sleep, such as in a cell. We have been informed that the in-ductwork automatic fire detection was installed in two wings (including House Block 4) as a trial, but was not found to be effective, though the equipment continued to be serviced and tested. The basis upon which this servicing and testing was carried out is still a matter of investigation, as the fitness for purpose of such equipment is one of the fundamental parameters of validated servicing and testing arrangements, and no documentation on this has yet been provided. The in-ductwork automatic fire detection failed to operate at the time of the fire. This method of installation is unlikely to provide adequate protection from fire to those in a cell.

'The consequence of the lack of effective in-cell fire detection was that the fire could not be detected automatically until smoke from it had forced past the cell door and risen to the level of the beam fire detection in the atrium. This is not a recognised standard of automatic

fire detection for a sleeping area, and will cause a significant delay before a cell fire is detected automatically.'

201. We note that there are still some prisons which have no in-cell smoke detection systems. We understand that NOMS are still working towards ensuring that in-cell smoke detection is installed across the entire prison estate.
202. No work had been done to improve the in-cell smoke detection system between the completion of the houseblock risk assessment and the cell fire. The fire safety advisor has now reiterated his recommendation that a better in-cell smoke detection system needs to be installed in cells across the prison and has asked the management team at Holme House to submit a bid for funding to NOMS.

Venting of smoke

203. The fire safety advisor told the investigators that the automatic venting system in the roof of C wing on Houseblock 4 proved unsatisfactory during the cell fire. After the fire alarm automatically triggered on the landing, vents in the roof opened, supposedly to allow smoke to escape. However, the open roof actually had little or no effect and the thick black smoke simply gathered on the wing, rather than dissipating as expected.
204. The vents in the roof are serviced twice a year. They are tested every week because they are automatically linked to the fire alarm. The venting system is part of the original roof installed when Holme House was built 20 years ago. There is no extraction process which actively sucks the smoke out of the building. The vents are simply intended to allow the smoke to dissipate.
205. CPIG inspectors have found that the effectiveness of fire safety measures at Holme House such as the vents was not calculated or tested either at the time of construction or during routine maintenance. There was no evidence to demonstrate that the smoke control system could be effective in the event of a fire. CPIG inspectors thought that any risk assessments were therefore meaningless because the assessors lacked the necessary knowledge about the effectiveness of the fire safety systems. CPIG inspectors comment in their report:

'The behaviour of the smoke was readily foreseeable by a competent fire risk assessor, and should have been identified as a significant issue in the fire risk assessment.'

206. The fire safety advisor has recommended further examination of the automatic vents in the roof and exploration of the reason why these did not effectively remove the smoke during the cell fire.

Access to hose and water misting unit

207. There is a hose located at the end of each landing in the centre of Houseblock 4. On 2 November, this was unfurled from its reel and laid out near to the cell at the earliest opportunity. The hose worked effectively throughout the incident.
208. Water misting units provide a more effective means of containing cell fires. They pump tiny droplets of water into a confined space. The water misting units at Holme House were not located either on Houseblock 4, or sufficiently close by for one to be brought across during the fire. They are located in the segregation unit and the healthcare centre. Given that the man's disruptive behaviour at its most extreme caused him to be held in both locations, it would seem sensible to keep the water misting units where they are if resources are limited.

Inundation port

209. The inundation ports in the cell doors at Holme House are checked on a regular basis. Ideally, staff are supposed to inundate the cell within five minutes of a fire being identified. The inundation port in the middle of the cell door seized during the fire on 2 November and staff could not remove the inundation plug to insert the hose. In the end, they had to smash the glass in the observation panel to insert the nozzle and inundate the cell. This meant that there was both a delay in putting out the fire and an additional risk to both staff and the man from the broken glass. Immediately after the fire, once the door had cooled down, staff tested the inundation port again but it had seized permanently and the plug could not be removed with the key.
210. The Chief Executive Officer of NOMS wrote to all prison governors on 26 August 2010 about inundation ports. He referred to a previous incident during which the heat of a cell fire had caused the inundation port to fail. While he acknowledged the issue, NOMS do not seem to have taken any subsequent action to address potential problems between August 2010 and November 2011. The inundation port also seized during the fire at Leeds in 2005. Additionally, another inundation port at Holme House seized during a subsequent cell fire in the healthcare centre on 15 April 2012.
211. CPIG inspectors comment in their Fire Fatality Incident Report:
- ‘Our investigation identified that the inundation ports within the establishment are included on the cell door maintenance schedule, but only given a visual check. This check does not test whether the inundation ports are in efficient working order.’

Cell Snatch Rescue Equipment (CSRE) smoke hoods

212. CSRE smoke hoods are bright orange in colour. Once donned, they form a seal around the individual's neck which staff agreed successfully kept smoke out on 2 November. However, the negative consequence of the hoods was

that staff found it virtually impossible to communicate with each other and their field of vision was significantly reduced.

213. In 2009, CSRE replaced Short Duration Breathing Apparatus, which the Prison Service had been using. CSRE is intended only for the immediate action needed to save a life during a cell fire and not for fire fighting. It provides staff with up to 15 minutes protection from smoke and toxic fumes. The smoke hoods are only intended for short rescue attempts (less than 10 minutes) and therefore are only supposed to be used when the user can quickly access a cell. They were never intended for the type of protracted incident which took place on 2 November.
214. After the sounding of the general alarm, 23 minutes passed before the man was pulled from the cell. The smoke hoods only last for a maximum of 15 minutes. Staff donned the hoods at 4.35pm, but by 4.51pm, when they entered the cell, they were already ineffective.
215. Indeed, it was felt by the officers we spoke to that the smoke hoods would work well in the event of a rapid cell snatch lasting a couple of minutes. However, the intensity of the smoke on this occasion, its rapid spread onto the landing, and the length of time it took to access the cell because of the barricade meant that staff observed significant drawbacks to the equipment. They felt compelled to lift up their hoods to shout orders and requests. The hoods expired before the emergency had ended. We understand that the fire safety advisor has already alerted NOMS to the difficulties encountered with regard to communication.
216. The duty governor thought that the smoke hoods were 'hopeless' for the task at hand. He described communication at the scene as 'horrendous' because of the restrictions of the hoods and the amount of smoke. He did not think that the CSRE was suitable for this type of cell fire. He commented that the hoods' 15 minute lifespan was insufficient for an incident involving a barricade.
217. The Sister's reported that the visor in her hood steamed up, making it hard to see. The PESO found that it proved difficult to shout to colleagues through the smoke hood. He commented that he was able to manage basic communication with the other officers at the cell door but could not communicate with other staff further down the landing.
218. Officer E agreed that communication was muffled and she and her colleagues inevitably had to lift the seals of their hoods to shout instructions. However, she said that the hoods were 'very effective' at keeping smoke out once the seal was in place.
219. Officer C removed his hood more frequently than his colleagues and suffered the worst smoke inhalation. Even after he broke the seal because he could not hear or make himself heard, communication proved difficult. He reflected during interview that the volume of smoke must have muffled any sound. He told the investigators that he did not wear the gauntlets that could have

protected his hands. He agreed that he was lucky not to have sustained burns.

220. The staff who went into the cell had received CSRE training. It is therefore reasonable to conclude that the communication problems they experienced were caused by the smoke hoods rather than a lack of training. We make the following recommendation:

The Chief Executive Officer of NOMS should commission a review of fire safety systems at Holme House which assesses:

- **the effectiveness of the in-cell smoke detection system.**
- **the effectiveness of the automatic venting in the roofs of houseblocks**
- **the need for water misting units on every unit**
- **the seizure of the inundation port**
- **the need for equipment to tackle fires of longer duration potentially involving a barricade**
- **the effectiveness of the existing CSRE smoke hoods**

The CEO of NOMS should ensure that any lessons are learnt both locally and nationally.

221. The general alarm was activated before the fire alarms on the landing and in the cell triggered automatically. Although it remains unclear who pressed the general alarm, staff speculated to the investigators that the individual concerned pressed it because they were unable to reach the fire alarm, which was situated beyond the man's cell at the end of the landing.
222. Staff from other houseblocks anticipated from a general alarm that they might be required to break up a fight and quite understandably did not collect smoke hoods when they left their houseblocks. Some officers turned back en route when they heard the subsequent fire alarm in order to do so, but this caused an inevitable delay in sufficient numbers of smoke hoods arriving at the scene. CPIG inspectors think that 'the dislocation caused by the initial use of the C&R alarm may go some way to explaining the slow progress made towards rescuing the man during the incident'. We make the following recommendation:

The Governor should commission a review of the location and quantity of fire alarm call points and ensure any necessary alterations to achieve appropriate safety standards.

223. At the time of the cell fire, there were 19 smoke hoods stored in Holme House. There were two on each of the seven houseblocks, two in the healthcare centre, two in the segregation unit and one in the orderly office. Ten hoods were brought to the scene and used during the fire, although staff asked for more and ran out of fresh hoods. The duty governor told the investigator that he had to send staff onto smoke-filled landings to unlock and

evacuate the prisoners. For this reason, he thought that more hoods were needed on each houseblock.

224. Since the cell fire, the fire safety advisor has already recommended to his managers that the number of smoke hoods on each houseblock be increased from two to three. We are pleased that Holme House has tried to proactively learn lessons from the incident. We make the following recommendation:

The Governor should ensure that three smoke hoods are stored in identical locations on each houseblock.

225. A manager at the scene is supposed to monitor the number of available fresh smoke hoods and stand down staff whose smoke hoods have expired. During the cell fire, officers went into the cell despite their smoke hoods having expired. The coordination of available smoke hoods needs to be improved during a future emergency by assigning this task to one individual. On 2 November, nobody seemed to have complete oversight of the CSRE or the cell rescue. This was because the amount of smoke on the landing prevented the orderly officer from being able to verbally instruct the officers at the cell door. There was little strategic coordination. We make the following recommendation:

The Governor should ensure that, in the event of a fire, a single member of staff coordinates the Cell Snatch Rescue Equipment and withdraws staff if they do not have access to a working CSRE hood.

CSRE training

226. The fire safety advisor also wrote in his risk assessment for Houseblock 4:

‘Fire safety training is currently in arrears, but however a programme for 3 yearly training has been scheduled.’

227. Since the cell fire, he has reiterated his recommendation that more staff need to be fire safety and CSRE trained. He told the investigators that he would like 90 percent of uniformed staff to be CSRE trained. He thinks that this target is achievable. He conceded that not enough staff were trained at the time of the cell fire.
228. As of 2 November 2011, 133 staff at Holme House were CSRE trained out of a total of 410. In the first month after the fire, a further 32 staff were fire safety trained and a rolling training programme is being run every Tuesday. Not all of the senior management team (SMT), including the duty governor, were CSRE trained at the time of the fire. The fire safety advisor has now recommended that all of the SMT receive training. During our investigation of a fatal cell fire at HMP Durham in 2005, we highlighted the lack of fire safety training amongst senior managers.
229. The fire safety advisor has amended the content of the fire safety training programme to take account of the events of 2 November. He has

recommended that the use of the anti-barricade allen key be incorporated into the course. There are two different types of anti-barricade stops in use at Holme House, so staff will be trained to remove both. We make the following recommendation:

The Governor should ensure that sufficient staff have current CSRE and fire safety training, including all of the Senior Management Team. This training should include the removal of the anti-barricade stop.

230. The fire safety advisor's risk assessment for Houseblock 4 also found:

'All fire hose reels are in place and inspected monthly and serviced by a competent person annually. Cell inundation keys are placed in hose reel cabins, cell inundation ports are serviced by prison service works staff on every 3 month period. All staff have access to safe system of work [the local policy] regarding cellular fires.'

Evacuation from C wing

231. Fire drills are held in Holme House on a rolling monthly programme. A different area of the prison is involved each time and wing evacuations are performed. The difficulty that prisons face is that the population is constantly changing as men are received into and released from custody.

232. On this occasion, all of the evidence shows that the evacuation went smoothly and that the prisoners on C wing complied with staff who unlocked them when the thick smoke began to spread down the wing. Staff lined the route to the gym and all of the prisoners were accounted for. The prisoners were safely held in the gym and then returned to C wing by the early evening to complete their regular association period. Staff were understandably keen to restore order and normality after such a disturbing incident.

Opening the cell door

233. Staff initially managed to push the cell door open six inches and then a few minutes later pulled it open fully once the anti-barricade stop was removed. The PESO told the investigators that he was in the path of any possible backdraft when he and his colleagues fully opened the cell door outwards and oxygen was able to rush in. Officer C similarly indicated that he did not consider the potential for backdraft at the time.

234. Fortunately, the officers did not encounter any flames or backdraft on this occasion. Because the observation hatch had been smashed and the door forced open a few inches, staff had already had the chance to thoroughly inundate the cell. The cell was wet and sooty and the fire had died down. Additionally, the door had been ajar for some minutes, allowing oxygen to enter the room gradually.

235. We make no criticism of the staff but we are concerned that they could have jeopardised their own safety when they opened the cell door. Staff are

instructed during fire safety training to stay low to the ground and remain behind a door when they open it. We want officers tackling any future cell fire to bear this advice in mind at all times. We would ask the fire safety advisor to stress this message during the local fire safety training course and make the following recommendation:

The Governor should ensure that fire safety training includes a reminder to staff to stay low and use the door as protection when opening the door during a cell fire.

Anti-barricade allen key and the proposed grab bag

236. Each houseblock holds an allen key which can be used to unscrew the anti-barricade stop on each cell doorframe. This key should be kept secure. At the time of the cell fire, the allen key was kept on Houseblock 4 in a padlocked cabinet. There was a delay in retrieving this allen key and bringing it to the man's cell because the cleaning officer who carried the key to the padlock had left the wing to evacuate prisoners to the gym. It subsequently emerged that there was another allen key in a drawer on the houseblock, but the staff present during the emergency were unaware of this.
237. Although staff knew by about 4.15pm that the man had erected a barricade, the anti-barricade allen key was not brought to the cell until 4.51pm. This was the result of a failure in communication. Some of the staff who tackled the fire were unaware that he had barricaded himself in.
238. As a result of lessons learned on 2 November, the fire safety advisor has already recommended that a grab bag containing cell inundation equipment should be located in the centre office of every houseblock. This measure will ensure that any member of staff arriving from another part of the prison knows immediately where to find the grab bag. The bag will contain tools to tackle a cell fire. A duplicate set of the same items will still be kept in the Senior Officers' office on each houseblock. The grab bag will contain:
- goggles
 - two sets of fire retardant gloves
 - a hammer (The security governor has agreed that a hammer can be part of this kit. Previously a hammer was required to be locked in a secure cabinet.)
 - an anti-barricade allen key and screwdriver
 - a star shaped key and screwdriver for certain doors
 - an inundation port key
 - a maglite torch
 - spare batteries for the torch
 - a mouth shield for delivering breaths during CPR
 - an inventory list

239. We make the following recommendation:

The Governor should ensure that the proposed grab bags for use during a cell fire are located in the centre office of each houseblock.

240. We also consider that there is an important point of learning here for the whole estate, notwithstanding our earlier recommendation to the Chief Executive. It became clear during our interviews that equipment was kept in different locations on each houseblock. This meant that staff arriving on Houseblock 4 were not immediately aware of where they could find the allen key. While this issue has been addressed at Holme House, it seems sensible to ensure that all prisons ensure that emergency equipment is located in standard locations across the prison. We make the following recommendation:

The Chief Executive Officer of NOMS should advise all Governors that emergency equipment should be held in standard locations throughout each prison.

241. Staff could not find a working torch on Houseblock 4 during the cell fire. However, most of the officers who the investigators spoke to agreed that even the strongest torch would have struggled to penetrate the thick black smoke pouring out of the cell. Nonetheless, Officer C thought that a torch would have at least helped the subsequent cell search. We are pleased that a maglite torch and spare batteries will now be included in the proposed grab bag.

Cardiopulmonary resuscitation

242. The investigator wrote about the emergency medical response in his clinical review:

‘The emergency response by healthcare staff and subsequently the paramedics was appropriate and professionally carried out in the clinical reviewers’ opinion. A doctor was present throughout the resuscitation attempts and from reviewing the interview transcripts the Clinical Reviewers conclude that both prison and healthcare staff made their best efforts to attempt to revive the man.’

Emergency services

243. The fire alarm triggered at 4.32am. Control room staff called the fire service at 4.35pm. However, they did not call the ambulance service until 4.40pm. It appears that discipline staff waited for the emergency medical response nurse (Hotel 2) to request an ambulance.

244. Given that staff had almost instantly witnessed billowing black smoke on the wing, knew that this was not a false alarm and knew that the man had erected a barricade, we think that the ambulance service should have been called at the same time as the fire service. We make the following recommendation:

The Governor should ensure that, in the event of a cell fire, discipline staff request the fire service and the ambulance service at the same time.

245. Although the fire engine arrived at the prison gate at 4.43pm, fire service staff did not then reach Houseblock 4 for a further ten minutes, shortly after the prison officers pulled the man out of the cell at 4.53pm. They described a slow procession through the prison, hindered by staff stopping to unlock and then lock each gate in turn. CPIG inspectors comment in their report about the cell fire:

‘The HMP Holme House Fire contingency plan allows a “clear path” approach to be authorised for fire service vehicles, but this was not provided because the instruction was not given, and the Gate staff had not been alerted to the full situation. Had the contingency plan been implemented fully, fire-fighters would have reached the scene several minutes earlier, and may have been able to rescue him at an earlier point.’

246. We make the following recommendation:

The Governor should ensure that staff prepare an unobstructed route from the gate to the wing to allow emergency services personnel to reach an incident without delay.

Staff support

247. Without exception, all of the staff the investigators interviewed, especially the officers who tackled the fire and were particularly affected, agreed that they had been very well supported by colleagues and managers after the cell fire. Staff have had a number of opportunities to debrief and discuss the incident. They were offered the services of the care team. We recognise that it was good practice for a member of the care team to accompany the officers suffering from smoke inhalation to hospital.
248. The investigators were keenly aware that some of their interviewees were still coming to terms with the events of 2 November and had been significantly affected by them. We make the following recommendation:

The Governor should ensure that the care team continue to check the welfare of staff who tackled the cell fire.

CONCLUSION

249. We will never fully understand the man's behaviour between 31 October and 2 November. His actions were unpredictable, often aggressive and sometimes endangered staff. At every stage the discipline and healthcare staff tried to keep him safe and locate him appropriately. They checked for withdrawal symptoms and found none. They planned to refer him for a mental health assessment. Shortly before the cell fire, they locked him in his cell to protect other prisoners. We do not think that staff could reasonably have predicted his actions. There was no available evidence that should have necessarily prompted self harm monitoring.
250. Once the fire started, it is hard to see how the staff who tackled the fire could have done any more to save him. The barricade that he had erected proved very effective.
251. While we think that the actions of the staff who tried to help the man were highly commendable, we were concerned by a significant number of failings in the fire safety systems at Holme House. A number of these failings appear to have implications for other prisons in England and Wales. The seizing of the inundation port (common to other cell fires), the way in which the vents failed to extract smoke from the houseblock, the failure of the in-cell smoke detection system and the need for fire safety equipment to be easily and centrally located are all issues that require urgent attention.

THE RESPONSE FROM THE MAN'S FAMILY TO THE DRAFT REPORT

252. Our family liaison officer provided the man's sister and partner with copies of the draft report. His partner responded, explaining that, apart from a brief half hour meeting, she had last seen him on Wednesday 26 October, five days before he was imprisoned. She is convinced that he must have displayed signs of withdrawal in Holme House due to the amount he used to drink. She said that he would shake so much that he could not even hold a cup. She is convinced that her partner must have been shaking and sweating in prison. She believes that his symptoms must have been missed by staff or overshadowed by his aggressive behaviour. She thinks that his attention seeking behaviour was linked to withdrawal symptoms.

253. She was disappointed by the failures in communication during the cell fire. She told our family liaison officer that the number of recommendations made by the Ombudsman left her with the impression that 'things had obviously gone wrong'. She agrees with our recommendations. She does not think that he meant to take his own life but rather that he set the fire as a last resort to attract the staff's attention and get the help he needed. She acknowledges that her partner 'got himself into a mess' but believes that he should not have died because:

- staff should have realised that he was withdrawing and treated him
- the fire should not have been able to take hold so quickly
- the response to the cell fire should not have had so many failings

RECOMMENDATIONS

For the Chief Executive Officer of NOMS:

1. The Chief Executive Officer of NOMS should ensure that the Head of Fire Safety is informed of all cell fires.

The Chief Executive Officer of NOMS accepted this recommendation and provided the following response:

‘The NOMS Incident Reporting System and RIVO [risk and compliance management software] will be developed so that the NOMS Fire Safety Team is informed of all cell fires.

‘A bulletin will be sent out by the Fire Safety Team to inform staff about the action that is required from them.’

2. The Chief Executive Officer of NOMS should commission a review of fire safety systems at Holme House which assesses:

- the effectiveness of the in-cell smoke detection system.
- the effectiveness of the automatic venting in the roofs of houseblocks
- the need for water misting units on every unit
- the seizure of the inundation port
- the need for equipment to tackle fires of longer duration potentially involving a barricade
- the effectiveness of the existing CSRE smoke hoods

The CEO of NOMS should ensure that any lessons are learnt both locally and nationally.

The Chief Executive Officer of NOMS accepted this recommendation and provided the following response:

‘Assessments of all the issues highlighted will take place in conjunction with relevant stakeholders from within the Ministry of Justice / NOMS.

‘A full report will be produced which covers all the salient points and will outline any significant findings/recommendations for improvement. Ian Mulholland (Wales Deputy Director of Custody) has been commissioned to undertake this review.

‘Reports will then be collated, including the initial fire investigation report that was completed by the Governor of HMP Wetherby.’

3. The Chief Executive Officer of NOMS should advise all Governors that emergency equipment should be held in standard locations throughout each prison.

The Chief Executive Officer of NOMS accepted this recommendation and provided the following response:

‘An assessment will be commissioned on behalf of each Governor to identify standardised locations for the safe and secure storage of essential fire safety equipment in their prison.

‘A bulletin will be sent out by the Fire Safety Team to inform staff about this.’

For the Governor of Holme House:

4. The Governor should ensure that all staff understand the instructions in Prison Service Order 1400 and take appropriate action when a prisoner erects a barricade in their cell.

The Governor of Holme House accepted this recommendation and provided the following response:

‘An instruction has been sent to all operational managers reminding them that a member of staff should remain at the cell when a prisoner has barricaded. This has been included in annual control and restraint refresher training that takes place on a monthly basis.

‘Training logs of all personnel will be updated and signed for to confirm receipt of training.’

5. The Governor should commission a review of the location and quantity of fire alarm call points and ensure any necessary alterations to achieve appropriate safety standards.

The Governor of Holme House accepted this recommendation and provided the following response:

‘A review will be commissioned as recommended. An immediate action will be to deploy appropriate signage to highlight where current alarm systems are.

‘This will be completed in conjunction with a member of the NOMS fire safety team and a member of the Technical Standards team.’

6. The Governor should ensure that three smoke hoods are stored in identical locations on each houseblock.

The Governor of Holme House accepted this recommendation and provided the following response:

'Additional smoke hoods have been purchased and received. These are placed together with the grab bags next to the centre office.

'In the event of a cell fire the 3 smoke hoods would be deployed. Holme House's safe system of work ensures that staff responding to the fire alarm will bring additional hoods from other areas. This ensures that an effective number of smoke hoods will be available throughout the incident.'

7. The Governor should ensure that, in the event of a fire, a single member of staff coordinates the Cell Snatch Rescue Equipment and withdraws staff if they do not have access to a working CSRE hood.

The Governor of Holme House accepted this recommendation and provided the following response:

'Contingency plans will be updated for incident scene Bronze (the manager at the scene of the fire) during a fire.

'An instruction will be issued to operational managers and also included in RPE (Respiratory Protective Equipment) training.

'The Fire Safety Practitioner will deliver additional training, in conjunction with national advice, to all operational officers. The additional training reinforces the importance of appropriate levels of responsibility, decision making and safe management and control of fire incidents.'

8. The Governor should ensure that sufficient staff have current CSRE and fire safety training, including all of the Senior Management Team. This training should include the removal of the anti-barricade stop.

The Governor of Holme House accepted this recommendation and provided the following response:

'Respiratory Protective Equipment (RPE) training is annual for all staff and currently scheduled on a weekly basis. Fire safety training is required every three years and is scheduled on a monthly basis. All members of the senior management team will attend RPE training. Anti Barricade training is already included in control and restraint and RPE training being delivered at Holme House.'

'The Fire Safety Practitioner has been set a target of training 80 percent of operational personnel by November 2012.'

9. The Governor should ensure that fire safety training includes a reminder to staff to stay low and use the door as protection when opening the door during a cell fire.

The Governor of Holme House accepted this recommendation and provided the following response:

‘This is currently included in the local Fire Safety Training courses.’

10. The Governor should ensure that the proposed grab bags for use during a cell fire are located in the centre office of each houseblock.

The Governor of Holme House accepted this recommendation and provided the following response:

‘The grab bags were introduced immediately after the cell fire. These have been located with the smoke hoods on each house block. Due to the size of the two cabinets required to hold them, these are located together on the external wall of the centre office on each house block. Keeping all these items together allows for a quicker response to any cell fire.’

11. The Governor should ensure that, in the event of a cell fire, discipline staff request the fire service and the ambulance service at the same time.

The Governor of Holme House accepted this recommendation and provided the following response:

‘Contingency plans and communication room instructions have been amended to ensure both emergency services are called for all cell fires.

‘This is reinforced to all staff as part of the weekly fire safety training sessions.’

12. The Governor should ensure that staff prepare an unobstructed route from the gate to the wing to allow emergency services personnel to reach an incident without delay.

The Governor of Holme House accepted this recommendation and provided the following response:

‘Contingency plans have been amended and this is reinforced to all staff as part of the weekly fire safety training sessions to ensure that procedures are improved to ensure a swifter access around the establishment for emergency services; however, security of the establishment will have to be maintained.’

13. The Governor should ensure that the care team continue to check the welfare of staff who tackled the cell fire.

The Governor of Holme House accepted this recommendation and provided the following response:

‘This is included and recorded as part of post-incident monitoring / Staff Welfare Assurance and the Care Team have continued regular contact with those staff involved in the incident.’