

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Craig a prisoner at HMP Guys Marsh on 16 September 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Andrew Craig died on 16 September 2016 of buprenorphine and diazepam toxicity at HMP Guys Marsh. Mr Craig was 30 years old. I offer my condolences to Mr Craig's family and friends.

Although Mr Craig's care, was mostly equivalent to that he could have expected to receive in the community, it is with grave concern that I have to make so many recommendations covering other areas. It is even more concerning that some of these recommendations relate to issues I have raised with Guys Marsh many times before - and are matters on which the Prison Service's own national instructions have been clear for so long.

The mental health team appear to have missed opportunities to see Mr Craig, staff did either not complete or act upon intelligence reports, prison policy relating to actions on receipt of intelligence reports is unclear, an officer did not check Mr Craig's wellbeing at unlock, a code blue was not called at the earliest opportunity and a hot debrief meeting does not appear to have been held after the event to offer staff support. I make a number of recommendations covering these areas.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

December 2017

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Summary

Events

1. On 22 March 2016, Mr Andrew Craig was sentenced to four years imprisonment for robbery. He had been at HMP Exeter on remand since 19 December 2015. Mr Craig was transferred to Guys Marsh on 23 June 2016. Mr Craig had a history of being involved in drugs and suspicious activity during previous sentences
2. During the three months Mr Craig was at Guys Marsh, between June 2016 and September 2016, staff made efforts to manage his mental health and substance misuse issues. However, it seems that some referrals to the mental health team went astray because the mental health team did not embrace the system used by other healthcare staff to make them. In terms of substance misuse help, during the last two months of his life Mr Craig declined what staff offered, but assistance was clearly available.
3. Mr Craig aroused suspicion regarding drug use through the entirety of this sentence. Healthcare assistants, nurses, doctors and pharmacy assistants at Guys Marsh all recorded their suspicions that he was drug-seeking, exhibiting behaviour suggesting he was using drugs or that he blatantly told them he was buying them from other prisoners. Despite this, there are no records that healthcare staff ever shared their concerns with the prison's security staff.
4. Likewise, prison staff at Guys Marsh also filed a number of intelligence reports suggesting that Mr Craig was involved with drugs. There is no evidence of any searching or testing and the investigator has not received an explanation from the prison as to why.
5. At approximately 7.45am on 16 September, an officer unlocked Mr Craig's cell, but did not seek to get a response from him to check he was okay – the officer thought Mr Craig was asleep. The same officer re-locked Mr Craig's cell approximately an hour later and then unlocked it again at 11.15am. Mr Craig had still not changed position. Prisoners raised the alarm shortly after and officers attended the cell. They did not call a code blue immediately but contacted a prison manager who instructed them to do so at once. Nurses attended and concluded it was not appropriate to commence CPR (cardiopulmonary resuscitation – a life saving technique) and paramedics arrived and confirmed death at 11.40am.
6. There is no evidence that the prison organised a hot debrief to ensure staff were supported.

Findings

7. Although the clinical reviewer feels that on the whole, during the course of his sentence, the care Mr Craig received in terms of his mental health and substance misuse was good, in subsequent conversations with the investigator he agrees that the mental health referral system at Guys Marsh did not run smoothly. There is considerable doubt whether the mental health team picked up all the referrals healthcare staff made.
8. Despite a wealth of intelligence suggesting Mr Craig was involved in drugs at Guys Marsh, there is no evidence of any pro-active investigation. Healthcare staff did not share information with security staff. Prison staff most certainly did by filing numerous intelligence reports, but there is no evidence that the security department sought to look into the matter further. From what we have seen of the prison's drug policies there seems to be a gap in this stage of the process.
9. At unlock, an officer did not seek to get a response from Mr Craig or call a code blue immediately when prisoners made staff aware something was wrong. After the event, prison managers do not appear to have arranged a hot debrief to offer staff support and ensure they were fit to continue with their shifts.

Recommendations

- The Head of Healthcare should ensure that a system is in place to guarantee mental health referrals are effectively scheduled and that all staff understand and use that system.
- The Head of Healthcare should ensure that staff know how to complete and process intelligence reports.
- The Governor should ensure drug policies clearly reflect what action staff should take once intelligence reports pertaining to drugs are received.
- The Governor should ensure that the prison's policy regarding unlock procedures is in line with national guidelines and that all staff understand what is required of them.
- The Governor and Head of Healthcare should ensure that staff are familiar with emergency code procedures.
- The Governor should ensure that after a death in custody, a prison manager holds a minuted hot debrief meeting with all relevant staff

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Guys Marsh informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator obtained copies of relevant extracts from Mr Craig's prison and medical records.
12. The investigator interviewed a member of staff by telephone on 3 August 2017.
13. NHS England commissioned a clinical reviewer to review Mr Craig's clinical care at the prison. When we issued our initial report we did not have the commissioners' quality assured version of the clinical review. We have received it now and replaced the original clinical review with the quality assured version. It has not been necessary to amend our report or recommendations.
14. We informed HM Coroner for Bournemouth and Poole Eastern District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Craig's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not raise any concerns.
16. Mr Craig's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Guys Marsh

18. Guys Marsh is a medium security prison that holds up to 579 men. Dorset University Healthcare Foundation Trust provides primary and secondary mental healthcare and has commissioned another agency, EDP, to provide integrated substance misuse services. Healthcare is open at weekdays and weekends from 8.30am to 6.00pm and there a doctor is on duty on Saturday mornings.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Guys Marsh was in December 2016. Inspectors found that overall they were very disappointed with what they found and that Guys Marsh had not improved greatly since their last visit. As before, however, they found healthcare to be largely good although they noted some problems with the supervision of the pharmacy hatch which created opportunities for diversion and violence. Compared to a comparator prison where 43% of prisoners said it was easy to get drugs, 74% of prisoners at Guys Marsh said it was easy. Issues were identified with infrequent drug testing, an insecure perimeter fence, high levels of victimisation on the drug treatment wing, an increase in violence overall due to drugs debts, limited analysis of drug and security information and PPO recommendations not being addressed. Some useful actions had been taken to reduce supply but there was no strategic approach to coordinate them. Clinical reviews were considered to be good and psychological services improved.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to November 2016, the IMB noted that a lack of staff had seriously inhibited the prison's ability to work properly. The board reiterated previous concerns about the availability of drugs and the knock on effects such as debt and psychosocial impacts.

Previous deaths at HMP Guys

21. Mr Craig's is the fifth death at Guy's Marsh since the beginning of 2016. We have made recommendations about emergency response and unlock procedures before.

Key Events

22. On 22 March 2016, Mr Andrew Craig was sentenced to four years imprisonment for robbery. He had been at HMP Exeter on remand since 19 December 2015. Mr Craig was transferred to Guys Marsh on 23 June 2016. While at Exeter, staff had completed intelligence reports regarding Mr Craig receiving an illicit postal order and suspicions about his involvement with drugs. During a previous sentence many reports were raised detailing his involvement in prison drug culture and trafficking items.
23. On 23 June 2016, a nurse did Mr Craig's first night health screen at Guys Marsh. She recorded that he was well presented and coherent, wanted to engage with the mental health team and consumed approximately five units of alcohol a week in the community. She measured his height (1.82m), weight (93kg) and blood pressure 147/82 (ideal is 120/80).
24. On the same day, a prison GP prescribed amitriptyline (an antidepressant), concerta (for Attention Deficit Hyperactivity Disorder) and tramadol (for pain management – Mr Craig had a herniated disc).
25. On 24 June, a prison GP saw Mr Craig and discussed his feelings that tramadol was not helping to relieve his pain. The GP agreed and noted that they would try and 'detox for it'. Mr Craig told him that he had been 'buying' Pregabalin and the doctor advised him not to do this and prescribed gabapentin instead. Pregabalin can be taken to treat neuropathic pain but is also taken illicitly (often combined with depressants) to sedative effect. Gabapentin is commonly used to treat neuropathic pain and epilepsy. Mr Craig also expressed that he was concerned about covering the cost of his Pregabalin use, that he felt insecure in prison and felt that he might get into trouble. The GP felt that a referral to the mental health team was appropriate and made one that day. There is no evidence to suggest that he reported the Pregabalin matter to security.
26. On 27 June, a drug worker recorded that Mr Craig had declined his offer to work with the Substance Misuse Team, but that he had told him he could apply when he was ready.
27. On 13 July, a healthcare assistant (HCA) saw Mr Craig. She found his behaviour childish and wondered if he was taking muscle enhancing substances. She also recorded that he was not taking his medication and she advised him that he should as he appeared to be experiencing mood swings. There is no evidence that she did anything to investigate whether he was taking muscle enhancing substances.
28. On 19 July, an administrator recorded that a primary care mental health team meeting was not held that day but that the HCA had been through the 'tasks'. (Healthcare's computer system holds prisoners' medical records and is called SystemOne. It contains a tasks section through which all requests and referrals are made.) She noted that no further primary care team mental health input was

required regarding Mr Craig, but that because he was on Concerta he had been referred to the secondary care mental health team.

29. On 28 July, a pharmacy technician noted that Mr Craig had said that he didn't like taking his medication, that Concerta wasn't working for him and he had been buying Pregabalin on the wing for his back issues. He wanted to be prescribed Pregabalin but was told this was unlikely to happen and he would probably be offered an alternative. She made an appointment for him to see a GP. There is no evidence to suggest that she reported the Pregabalin matter to Security.
30. On 4 August 2016, a prison GP recorded that recent investigations showed Mr Craig had a slightly herniated disc but no nerve compression, and she felt he was 'drug seeking'. She refused to prescribe Pregabalin but prescribed Duloxetine (a drug for depression, anxiety and neuropathic pain). She also agreed to prescribe Zopiclone (a sleeping tablet) as a one off as his friend's funeral was coming up.
31. On 12 August, a nurse conducted Mr Craig's mental health review (presumably as a result of the referral made on 19 July although this is a long gap). He told her he had not been taking Concerta for a month and would like to consider an alternative to it, that he wanted sleeping tablets and admitted that he was still buying Pregabalin on the wing. She concluded that he needed a medication review and that he should speak to a GP about sleeping tablets, but there is no evidence she reported the Pregabalin issue.
32. On 13 August, a prison GP saw Mr Craig and talked to him about restarting 'Concerta'. He noted he would not consider prescribing sleeping tablets until Mr Craig had been back on Concerta for a month, although the SystmOne records denote that on 15 August another GP prescribed Zopiclone.
33. Also on 18 August, an intelligence report was completed relaying a conversation Mr Craig had had with staff implying that he may be in possession of a mobile phone.
34. On 22 August, a HCA saw Mr Craig, who told her he was worried his mental health was getting worse and giving him sleep problems. She explained that Zopiclone (a sleeping pill) was not a remedy and that to try and get to sleep naturally would be better. She gave him some 'sleep hygiene' leaflets and said she would send the mental health team a message to see him again. There is nothing on the medical records to suggest anyone did but the Head of Healthcare has suggested that someone may have sent an email instead - the fact an appointment took place on 26 August, supports this suggestion.
35. On 24 August, there is a note on Mr Craig's medical record that he did not attend a referrals appointment with the mental health team but it is not clear which appointment this referred to.
36. On 26 August, Mr Craig saw a nurse for a mental health review. She documented his long history of substance misuse and that he had taken Quetiapine and Pregabalin that day. She also noted she requested to have Concerta restarted and requested another nurse and a GP also possibly review Mr Craig. It is not clear if this review took place.

37. On 30 August 2016, Mr Craig saw a Support Time recovery worker, having self referred to her. He said he didn't need to work with the substance misuse team but wanted to check if it was on his sentence plan to do so. He told her about his historical crack use and that he felt he had grown out of his 'party era'. She discussed tolerance issues with him and gave him information about psychotic substances. She advised him to refer himself to the substance misuse team if he changed his mind.
38. Also on 30 August, an intelligence report was completed stating that Mr Craig had been discussing his weekend activity, that he said there had been a party on the wing and that he had taken some large and strong sleeping tablets.
39. On 1 September, Mr Craig attended the HCA's sleep clinic. She noted that his mood was erratic and she asked the mental health team to see him as she was concerned about his mental state although she also felt it was possible he was trying to dupe her. She sent a task to the mental health team via SystmOne.
40. On 1 September an intelligence report was also completed stating that Mr Craig had told staff that he was in a relationship with a female officer from HMP Exeter but that she had resigned from her post.
41. On 2 September, another intelligence report was completed stating that Mr Craig had had a telephone conversation with a female, the content of which suggested he was in possession of a mobile phone.
42. On 7 September, yet another intelligence report was completed stating that a prisoner told staff that a prison officer from HMP Exeter visited Mr Craig.
43. Also on 7 September, an assistant practitioner noted that Mr Craig had asked when the mental health team were going to see him and that he had sent a task to the team so they could arrange one. It is not clear what became of this referral.
44. On 9 September, a prison GP saw Mr Craig and recorded that he was 'drug seeking again' asking for more Tramadol and Zopiclone. He told her he was losing sleep and depressed as a result of neuropathic pain. She told him to try the Duloxetine at a higher dose, but recorded that he was not prepared to listen although she prescribed it anyway.
45. On 14 September, an entry was made in the wing book (the author's name is not decipherable) stating that Mr Craig told officers he was getting sleeping pills from another prisoner. 'Action to be taken' is recorded as 'IR' (intelligence report).
46. An intelligence report was completed on the same day stating that at an assessment interview, Mr Craig had told a member of staff that he had trouble sleeping but had to get to get tablets off prisoners on the wing as healthcare would not give him any.
47. On the evening of 15 September, at approximately 6.00pm Mr Craig chatted to a prisoner friend who reported that Mr Craig did not seem unwell or as if he had taken anything. An officer also spoke to him that evening, at an unspecified time, when he locked Mr Craig up. Mr Craig told him he had not been sleeping well and hoped he would get some that night. The officer had no concerns about Mr Craig.

48. HMP Guys Marsh was unable to provide a cell bell record for that night. The investigator was told 'Guys Marsh does not have a cell bell system that records when cell bells are activated and when they are responded to'. We, therefore, do not know if Mr Craig tried to summon help that night.

The Emergency Response

49. On 16 September, at 7.30am, Officer A started the roll check on Wessex wing. He saw Mr Craig on his bed with the television on and as far as he was aware there were no issues.
50. At 7.45am Officer A and Officer B began to unlock the prisoners. Officer B unlocked Mr Craig. Officer A's statement said that at unlock the deadlock on the cell is unlocked but the privacy lock is left on and the cell is not opened. Officer B's statement said that he looked through the observation panel of Mr Craig's cell and did not go in. He saw Mr Craig lying on his bed clothed, and thought he had fallen asleep watching the television. He did not notice anything unusual and said he knew that Mr Craig often slept until after 11.00am.
51. Between 8.45am and 9.00am, officers locked up all prisoners who had not gone to work. Officer B locked Mr Craig's cell up and noticed that he was in the same position he had been at unlock. He said the light in the cell was quite dim and he could not see Mr Craig's pallor, but he was not alarmed that his position had not changed. At approximately 11.15am, he unlocked Mr Craig's cell again in preparation for lunch. Again he thought Mr Craig was still asleep, and was not alarmed that he had not moved.
52. At approximately 11:20am, Officer A was in the wing office when a prisoner ran in, grabbed the 'courtesy' key to Mr Craig's cell and ran out again. He ran after him asking what he was doing and the prisoner replied that he was going to check on Mr Craig. The prisoner passed the key to another prisoner who unlocked Mr Craig's cell, went in, shook him and shouted at him to wake up. The officer ordered the prisoners out, turned on the light and shouted for staff support.
53. Two officers attended the cell. Officer C described Mr Craig as being in a natural position on the bed, looking as if he had been watching television with the remote in his hand. He touched Mr Craig and he was cold and not breathing. He could see that Mr Craig's arms were discoloured and thought that he was dead. He called for assistance on his radio.
54. In the meantime, Officer B contacted the Custodial Manager (CM) by radio and told her there was a prisoner who was not breathing. She told him to call a code blue, which he did immediately. The time was 11.27am and staff in the control room called an ambulance at 11.29am.
55. The CM attended the scene straight away and directed staff to lock prisoners up while an officer went into the cell to join Officer C. They came out again shortly after and told her they thought Mr Craig was dead. She noted that Mr Craig's eyes were open he was cold and had no pulse.

56. Two nurses arrived but we have been unable to establish at what time. The statements taken by the police nearer the time did not specify and no CCTV or body camera footage is available. When at our request the Head of Healthcare queried the timings with a nurse some months later, she estimated 11.00am - but this could not have been the case. The nurses agreed that CPR (cardio pulmonary resuscitation – a life saving technique) was not appropriate and waited for the paramedics to arrive.
57. At 11.40am paramedics arrived and pronounced Mr Craig dead. They thought Mr Craig had been dead for approximately six hours.
58. On 18 September, an intelligence report was created stating that an informer had told staff that Mr Craig had been holding drugs for another prisoner considered to be the main drugs and phones supplier in the prison. The informer also told staff that the night before he died Mr Craig had told him he had taken '1200 gabs, pre gabs and M-Cat' referring to Pregabalin and another drug also known as Mephedrone.
59. On 7 October, an intelligence report was created stating that a Blackberry mobile phone was recovered from Mr Craig's sealed cell.

Contact with Mr Craig's family

60. A CM was appointed as the prison's family liaison officer at midday. She established that the next of kin lived a substantial journey from the prison (Guys Marsh is in Dorset and the family lived in Stafford). She contacted HMP Stafford, who deployed their deputy governor. He attended the family's address at 2.35pm and gave them the news and offered advice and support. The CM maintained further contact with the family after that point.
61. Mr Craig's funeral was on 19 October 2016. Prison staff did not attend at the request of the family but the prison offered a contribution to the costs in line with national policy.

Support for prisoners and staff

62. There is no evidence that after Mr Craig's death prison managers met with staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. We have repeatedly asked for minutes or information about a 'hot debrief', but none has been provided.
63. The prison posted notices informing other prisoners of Mr Craig's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Craig's death.

Post-mortem report

64. The coroner provided a copy of the post-mortem and toxicology report. The post-mortem gave the cause of death as toxic effects of buprenorphine and diazepam. The toxicology report also referred to the presence of Pregabalin and remarked that this was something Mr Craig was prescribed. The investigator has checked with the Head of Healthcare at Guys Marsh, who has confirmed Mr Craig was not prescribed this drug.

Findings

Clinical care

Mental health

65. The clinical reviewer concluded that in general the care Mr Craig received in respect of his mental health was good, but we have some concerns about what became of certain referrals that were made to the mental health team – specifically one made by a nurse on 26 August 2016 and another on 7 September 2016. The Head of Healthcare has told us there was a problem with the referral system in that the mental health team did not respond to ‘tasks’ sent via SystmOne. The mental health team felt that there wasn’t enough ownership re ‘tasks’ and that an email sent to an individual was the best way to ensure things were done. However, this method makes auditing more difficult especially when staff leave.

The Head of Healthcare should ensure that a system is in place to guarantee that mental health referrals are effectively scheduled and all staff understand and use that system

Substance misuse

66. The clinical reviewer is satisfied that although Mr Craig had a significant history of substance misuse, he was offered intervention to address it which he sometimes engaged with. However, he declined any support during the last two months of his life, once on 27 June 2016 and again on 30 August 2016, as was his choice to do so.

Security

67. There is evidence that some healthcare staff believed Mr Craig was a ‘drug seeker’ and he told some members on various occasions that he was buying drugs on the wing. A prison GP noted she believed he was drug seeking on 4 August 2016 and 9 September. Another GP noted on 24 June 2016 that Mr Craig told him he had been buying Pregabalin as did another GP on 28 July and a nurse on 12 August. On 13 Jul 2016, a HCA noted that she wondered if Mr Craig was taking muscle enhancing substances.
68. There is no evidence that any of these incidents were reported to security. The Head of Healthcare has told me that she would have expected healthcare staff to fill in intelligence reports, but there are no traces of any or that security were emailed to alert them to any concerns.
69. We asked a prison GP what she had done about her suspicions that Mr Craig was drug seeking. She told us that she would have raised it with staff, but was not specific about who or if she had done so in this case. When asked what the formal mechanisms were for reporting concerns regarding drugs she said that drug seeking was so common it was ‘par for the course’ and she did not inform

anyone officially when it happened. She said that if contact with Security was required, she would make it.

70. It is clear to us that healthcare staff did not consider drug seeking, self reports of drug taking or behaviour indicating drug taking as issues they should have reported – and it is questionable whether they knew how to do so.
71. Prison staff completed a number of intelligence reports. These included concerns that Mr Craig had a mobile phone and was buying and taking drugs on the wing; reports were filed on 18 August 2016, 30 August, 2 September and 14 September. A manager in the security department asked her staff to tell the investigator what action their records said had been taken in relation to these reports. An intelligence analyst sent the investigator a report which said that when Mr Craig was questioned about the phone he explained away remarks he had made alluding to one, saying that when he had said pictures were taken of an injury he meant staff in the Segregation Unit had actually taken these pictures, and not himself. The investigator asked the CM if Mr Craig’s explanation had been checked or if he had been searched for a mobile phone, but we are yet to receive a response. We also asked why no action seemed to have been taken in relation to the other intelligence reports, but again we have not received a response.
72. As HMIP highlighted in their report, there seems to be limited analysis of drug and security information. As the prison has not answered the investigator’s questions as to why this was also the case with information about Mr Craig, it is difficult to say whether it is purely a resource issue or due to a lack of strategic focus.
73. The prison provided copies of relevant policies that were in place at the time Mr Craig died. These included a Drug and Alcohol Strategy (issued in October 2013) and a Violence Reduction Strategy (originally issued in October 2015 and updated the day before Mr Craig died).
74. The Drug and Alcohol Strategy had three main themes: disrupting supply, reducing demand and treatment, support and through care. Its aims and objectives were to: restrict the availability of illicit drugs and alcohol in prison, identify prisoners who have been misusing drugs/alcohol, provide those prisoners with advice, treatment and support of appropriate intensity, including the arrangement of post release support where necessary, increase the provision of alcohol treatment as resources allow, prevent mental and physical substance misuse related harm to prisoners or others, reporting by the Drug Strategy Team to the Reducing Reoffending Meetings. It is not clear from the strategy, what action should be taken after intelligence referrals pertaining to drugs are filed, within what time frame or by whom. It does detail how healthcare staff were expected to report any suspected drug use or trading to the prison’s Senior Management Team. It also stipulated that a member of the healthcare team should act as a liaison point with the SMT.

The Head of Healthcare should ensure staff know how to complete and process intelligence reports.

The Governor should ensure drug policies clearly reflect what action staff should take once intelligence reports pertaining to drugs are received.

Unlock

75. At unlock, officers should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states that "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead".
76. Prison Service Instruction 75/2011 Residential Services states that:
- "Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight ... but staff unlocking them have not noticed that the prisoner had died. This is not acceptable...
- "[Differing] arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the well being of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process."
77. Officer B unlocked Mr Craig's cell at 7.45am. Officer A's police statement made it clear that at unlock, the deadlock on the cells were unlocked but the privacy lock left on and the cell door not opened. Officer B's statement said that he looked through the observation panel of Mr Craig's cell and did not go in. Officer A has since left the Prison Service, but we asked Officer B about unlock procedures. He said he did not seek to get a response from Mr Craig and that this was at the time usual when unlocking on that particular wing. He said this was because the two-locks design of the doors meant that officers did not actually open cell doors once they dealt with the deadlock. However, on other wings, where the cell doors were metal and only had one lock, unlock procedures were different - officers would open the cell door and speak to the prisoner inside.
78. We note that Officer B did not react to Mr Craig not changing his position over several hours, but we are also aware that the officer had been out of training for only two weeks, Mr Craig often slept very late and the light in the cell was dim so he could not decipher his pallor. However, prisoners appeared to notice very quickly that something was amiss. It is perfectly possible of course that they had the benefit of knowing Mr Craig had taken drugs the night before, but it highlights the importance of officer's assuring themselves of a prisoner's wellbeing.
79. The prison have not provided a copy of their local policy regarding unlock but it is clear that either the policy or staff's understanding of it needs to be addressed

The Governor should ensure that the prison's policy regarding unlock procedures is in line with national guidelines, on all wings, and that staff understand what is required of them.

Emergency response

80. Prison Service Instruction (PSI) 03/2013 requires prisons to have a medical emergency response code protocol, which should ensure that an ambulance is called immediately when a medical emergency is called. There should be no requirement for control room staff to check with managers, healthcare staff or others at the scene before calling an ambulance, but they should wait for updates and keep the ambulance service informed. The PSI notes that it is better to act with caution and request an ambulance that can be cancelled later if it is not needed.
81. The prison's local policy is in line with these guidelines, but Officer A did not call a code blue when he first entered Mr Craig's cell and realised something was wrong. Officers B and C also attended the cell but contacted a manager, rather than call a code themselves straightaway. She advised them to do so and paramedics arrived shortly after.
82. The emergency response in terms of summoning healthcare and an ambulance was very confused. Officer B told us that he knew a code blue was the appropriate response but he wasn't sure if anyone else had called one. Although it wouldn't have made any difference to Mr Craig (given paramedics thought he been dead approximately six hours) staff immediately calling a code could be vital in other cases.

The Governor and Head of Healthcare should ensure staff are familiar with emergency code procedures.

Support for staff

83. Prison Service Instruction (PSI) 64/2011 reiterates that in line with PSI 08/2010 Post Incident Care, a 'Hot Debrief' must be held immediately after the all deaths in custody. A senior member of staff must act as the debriefer and a member of the care team must attend. All staff directly involved in the incident, including healthcare staff, should be invited. The instruction says it may be useful to keep a record of those who attend.
84. The prison has not provided a copy of their hot debrief minutes or even details of the meeting, despite repeated requests. As such, we can only assume that they did not hold one and wish to reiterate the importance of doing so.

The Governor should ensure that after deaths in custody, a manager holds a minuted hot debrief meeting with all relevant staff.

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