

**Investigation into the circumstances surrounding the death
of a man at HMP Durham**

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

April 2010

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Durham on 15 June 2005. It would seem that he started a fire in his cell in the segregation unit, a cell in which he was the sole occupant, at about 7.05am that day. Fire brigade officers arrived at the prison at 7.11am and were escorted to the segregation unit. There are no records of timed activities from then but the fire fighters assessed that the fire was still active and one of their number, together with two prison officers, entered the cell some minutes later. Staff pulled the man out of the cell and he was taken by ambulance to University Hospital, Durham, where he died at about 2.50pm. The man had been taken into custody two days earlier (although he had been in HMP Durham three times before). He was aged 23.

I offer my sincere sympathy and condolences to the man's family who have suffered the tragic loss of a much loved family member.

My investigator carried out the investigation on my behalf. As part of his investigation he commissioned an independent review of the man's clinical management. I am grateful to the clinical reviewer who carried out the review on behalf of the Northumberland NHS Care Trust. I must also thank the Head of Technical Services for NOMS for his kind assistance on matters relating to the use of cardboard furniture and breathing apparatus.

Durham Constabulary conducted a protracted investigation of their own, but readily shared their information and kept in close touch with my investigator. I also appreciate the willing cooperation of the Governor and all staff at HMP Durham, notably the officer who acted as liaison officer.

I aim to report with such speed as is consistent with the need for a thorough investigation. Thankfully it is rare for a death in custody to be caused by fire. In this case the police investigation had primacy and I could not conclude my own investigation before the conclusion of police enquiries in March 2008. Since then my investigator has again visited the prison and police headquarters in Durham. He also conducted interviews with prison staff and met the man's family for a second time, a meeting which of necessity he had postponed pending the conclusion of the police investigation.

My report reveals great professionalism, sensitivity and outright bravery on the part of staff at Durham. However, for reasons that I explain, I also judge that the death of the man was preventable.

I make seven recommendations, all of which have been accepted, and record three examples of good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

The man was born in Gateshead and was brought up in the Gateshead area. His father, who came from Liberia, died when the man was an infant. His mother later remarried and, in addition to his sister, the man had three half-brothers.

The man had special needs from an early age and had spent time in secure psychiatric hospitals. At the time of his death, he had been found guilty of a total of 36 offences including, significantly, two of arson. He had been held in Durham prison on three occasions and twice had set fire to materials in his cell.

On 13 June 2005, the man appeared before Gateshead Magistrates' Court, charged with possession of a weapon (a knife), and threatening a railway employee and a police officer. He was remanded in custody to Durham to appear again before the Court on 22 June. The contractor's escorting staff who took the man to Durham believed that he might harm himself and raised a Suicide and Self Harm warning form, initially taking their own precautions and subsequently handing over all their information to reception staff at the prison.

On arrival at Durham, he was angry and disruptive in the reception area and was 'fast-tracked' through the admissions process. Although he was known to some staff at the prison, including the senior officer in reception, all members of staff dealing with him on this new admission told my investigator that they had neither access to documentation nor personal knowledge of his history of arson and fire-setting in prison. Had staff known that the man had previous convictions for arson and, on two separate occasions during 2004 had used his lighter to set fire to a prison plate and mattress, they may well have decided he should not have a lighter in his possession.

Having regard to fears that he might self-harm, the nurse on duty in the reception area initiated a formal Prison Service process to monitor and support prisoners at risk of self harm (the F2052SH). The process included regular observations and reviews by staff. The man was admitted to the healthcare centre.

During the evening the man slept, but he later awoke and played pool. The duty doctor visited while he was asleep and decided not to wake him. During the night the man destroyed furniture and fittings in his cell and next morning the managing medical officer, having consulted other members of staff, decided to move him to the segregation unit.

The man was allocated to a 'safer cell'. It had closed circuit television (CCTV) and moulded furniture. The locating officer allowed him to move to another cell as he said the first one brought bad memories. Also a 'safer cell', the second one was different to the first in that it had cardboard furniture. My report shows that there had been much debate and correspondence within the Prison Service on the use of cardboard furniture. Some, including safety advisors, advocated its withdrawal as it had proved combustible. The furniture in use was 'second generation' which was thought to be an improvement

on the earlier type but still known to be inflammable. It was coated with a substance designed to minimise the risk of catching fire and was a distinctive blue colour. Staff did not complete a risk-assessment, a requirement when consideration is given to locating a prisoner in a cell with cardboard furniture

A Prison Officer saw officers locating the man in his cell and questioned whether or not he should be allowed to keep his lighter. She did not say why she asked the question and, in the absence of detailed information, the Senior Officer in charge of the unit allowed the man to retain it.

The managing medical officer, a chaplain, and a probation officer visited the man during the day. He appeared to calm down but through the evening and night became increasingly violent, destroying furniture and fittings in his cell. Staff were in almost constant attendance.

At about 7.05am the following morning (15 June), an officer who was on duty in the segregation unit saw smoke coming from the man's cell and raised the alarm. Staff had no safe means of entering the smoke-affected cell and, although the Fire Brigade arrived within six minutes of being called, by the time they extinguished the fire, entered the cell and paramedics had attempted to revive the man, he was unconscious. He had apparently set fire to cardboard furniture in the cell and been overcome by toxic fumes. There was a great deal of water in the cell, introduced by staff in order to extinguish the fire and as a result of the man pulling the taps from his wash basin. When staff and fire service officers entered the cell, the man was lying under the bed. It is possible that both his nose and mouth were below the level of the water. The man died in hospital at 2.50pm the same day.

Several prison officers were treated for smoke inhalation at the hospital. One of them was given oxygen.

My report addresses many questions. How could Durham, having so much information about the man, fail to record and subsequently take account of his propensity to lighting fires? Why, with convictions for arson and unstable by temperament, did he have a lighter in his possession? Why did the officer not explain her reasons for asking if the man should have his lighter? Why did the officer locating the man in the second segregation cell, not call for a risk assessment? Why did cell furniture emit toxic fumes? Was Durham's policy of non-intervention by staff in case of fire appropriate? Does the Prison Service have a corporate policy on smoke protection for staff? If it does, do Governors adhere to the policy?

In places my report reflects great credit upon the Prison Service. However, I have also concluded that the death of the man was preventable. I have made seven recommendations, all of which have been accepted.

The inquest following the man's death was completed in March 2009 with the jury finding that his death was caused by carbon monoxide poisoning and inhalation of

smoke as a result of a cell fire between 7.04am and 7.20am on 15 June 2005. The jury answered in writing a large number of questions posed by the coroner and concluded that the man's death was due to misadventure.

THE INVESTIGATION

1. My investigation opened in June 2005 when my investigator visited HMP Durham. He met the Governor and Safer Custody Manager and later chaired a meeting of staff who had been involved in some way at the time of the man's death, including police officers and members of the Independent Monitoring Board. My investigator also issued notices advising staff and prisoners of my investigation and invited anyone who wished to see him to make themselves known. He received no requests but identified 12 members of staff, including the Governor, whom he would interview. He also conducted informal discussions with segregation and security staff, including managers and administrators.
2. My investigator visited the scene of the man's death and saw the cell in the condition it had been when the man died. The floor was covered with water to a depth of about 75mm. It was reasonable to assume that some water had drained off between the man's death and the visit. The cell and corridor were badly smoke-damaged.
3. An Inspector from Durham Constabulary advised my investigator that the police would hold an investigation into the circumstances of the man's death. A police investigation has primacy over all others and my investigator adjourned his investigation. He met the man's mother and his sister at their homes and explained that he had suspended his inquiries pending the outcome of the police investigation.
4. My investigator kept in touch throughout with all interested parties, including the family solicitor acting for the man's sisters. In 2006, he attended a meeting in Durham to establish the extent of police progress. The police subsequently reported their findings to the Crown Prosecution Service. When the CPS ruled in January 2008 that they would take no further action in respect of the man's death, my investigator resumed his enquiries. He visited Durham on 4 and 5 February 2008 and during two subsequent visits interviewed ten members of staff. He also visited Wetherby Young Offenders Institution and interviewed the Senior Officer (now Principal Officer), who had subsequently transferred to Wetherby. He held a second meeting with the man's family and their solicitor in May 2008.
5. My investigator retired after the inquest into the man's death was completed in March 2009 and the necessary work so that this version of my report could be issued has been undertaken by one of my Assistant Ombudsmen.

Meeting with the man's family

6. During August 2005, my investigator and one of my family liaison officers visited the man's sister at her home in London. They also visited his mother and stepfather in Gateshead. They met the family on a subsequent occasion, in May 2008, at the office of their solicitor. The purpose of these meetings was to allow the man's family to raise questions and concerns.
7. At the initial meeting the family raised a number of concerns:
 - The man's sister was angry at what she perceived to be a sarcastic comment made by the Governor of Durham during her telephone conversation with him at the time of the man's death. She said that when she asked him to go over events once again he was dismissive and ended the conversation abruptly.
 - They asked if the man had been prescribed medication and whether or not he had taken it.
 - They asked why the man had been allowed a lighter in his possession in his cell.
 - They asked what the man had used to cover the cell observation panel.
 - They asked why staff had not entered when they saw smoke and why it had taken so long to get the man from his cell.
 - They were upset that the man's cell had been cleaned prior to their visit to Durham. They had wanted to see it as it was at the time he died.
 - They had not received the man's personal effects, and they had been told conflicting stories about what he brought into Durham with him.
 - They wanted to know why there was no sprinkler system in Durham and why it had been possible for the man to set fire to the furniture.
 - Given his history, his family did not believe that staff did not know him and the risks he presented.
 - Above all, they wanted to know why he had been sent to prison in the first place. He was clearly mentally ill. They said that in a telephone conversation when the man was in police custody prior to being sent to prison he told his mother and his sister that he did not know why he was in prison.
8. At the meeting on 1 May 2008 following resumption of my investigation, my investigator and family liaison officer gave the man's mother, sister and partner an overview of the investigation. The family's solicitor was present at this meeting. They had neither further points to raise nor questions to ask.
9. The man's family added a great deal to my investigator's understanding of him as a person. They described him as loving, kind and caring and said that his great loves in life were his daughter, his family and music. He had a brilliant sense of humour and was often described as a big friendly giant.

10. I deal with the man's family's questions throughout this report. I trust I have addressed fully the matters which cause them concern.

HMP DURHAM

11. Durham was built in the early 19th century to what is now seen as the traditional Victorian design. Its operating capacity with overcrowding is just short of 1,000. The prison has undergone major refurbishment over the last decade, and my investigator judged that the accommodation and facilities are now in reasonable shape. But even though facilities are generally good, they are often stretched. HM Chief Inspector of Prisons, in a report of an unannounced inspection during August 2003, found the prison to be safe but under pressure from overcrowding. Significantly for the purposes of this report, it is important to note that the healthcare centre is almost always full, and sometimes has a waiting list.
12. Fire prevention arrangements in prisons are subject to legislation set out in the Regulatory Reform (Fire Service) Order 2005. Prison Service Order 3803 identifies the procedures all prisons must follow to ensure minimisation of fire risk and efficient processes for dealing with fires. Durham's arrangements are detailed in statements and local orders and, although there are water hoses and fire extinguishers in all communal areas, the Crown Premises Inspection Group (CPIG) in an inspection report of January 2005 identified insufficient attention to risk assessment, unsatisfactory escape routes, and lack of automatic fire detectors in many areas. The report also identified that only 35 per cent of staff, none of them governor grades, were trained in fire procedures. Prior to the man's death, there had been no previous death at Durham as a result of fire.
13. Care of prisoners who are likely to harm themselves, or attempt suicide, is arranged through the Safer Custody Management Team. Meetings are held monthly. Four meetings were held between 13 January and 26 May 2005, all attended in good numbers by senior and junior staff, Samaritans, the prison's Independent Monitoring Board, and by prisoners. My investigator examined the minutes which showed that at a typical meeting seven prisoners who had been trained as 'Listeners' attended. (Prison 'Listeners' are trained by the Samaritans and give peer support to other prisoners who may not want to talk to staff. Within the bounds of confidentiality, Listeners work also in conjunction with staff and the Samaritans.) Anti-bullying and race relations were meeting agenda items. Each case of self-harm was scrutinised and documentation was checked to ensure proper actions had been taken when a prisoner had been identified as likely to self-harm. My investigator also found that Samaritan and other appropriate notices are displayed throughout the prison. The Safer Custody Manager's report of 31 May 2005 showed that Samaritans visit the prison fortnightly. Nearly 500 staff had received the Prison Service's suicide awareness training.
14. My investigator met the Chair and one other member of the Independent Monitoring Board (IMB). The Board felt that the prison ran well with many caring staff, and praised the first night reception centre for prisoners, suicide awareness training which some IMB members had completed, the prisoner 'father and child' groups, and particularly the work of staff in the segregation unit. The Chair said

that an IMB member visited the unit two or three times a week. She had visited many prisons and Durham was the best she had seen. A difficult prisoner being held temporarily in the unit had told her that the staff were decent and helpful.

15. The chaplain, who knew the man well, told my investigator that in his view the most important issue is that Durham has many mentally ill prisoners. He said staff were 'brilliant' but could not cope with the huge problem. Neither could the healthcare centre which was always full and was rather like a psychiatric ward with added complications. He thought it was not fair that Durham should have to deal with the problem which was not about prison work. It was more about people who had been abandoned in the community. The chaplain summarised by saying, 'This is a prison, not a mental hospital. Staff and prisoners deserve better.'

EVENTS LEADING TO THE MAN'S DEATH

The afternoon, evening and night of 13 June 2005

16. On 13 June, the day of the man's arrival at Durham, a Senior Officer was in charge of reception and checked his documentation and property. The SO knew the man from two previous sentences, describing him as 'the most volatile, unpredictable and violent prisoner' he had seen in 22 years' service. He knew that the man had damaged the healthcare centre on a previous sentence but not that he had set fires in the prison or had previous convictions for arson. The SO said that he had no access to the man's previous records.
17. The SO told my investigator that, on his admission on 13 June, the man was 'verbally and physically intimidating, ranting and raving and swearing at everybody in sight. He had to be separated in the waiting area from other prisoners for their safety and we decided to fast-track his admission and get him dealt with as quickly and safely as possible.'
18. Another officer also on duty in reception said that he had no prior knowledge of the man. He completed documentation and on form XF001 'Cell Sharing Risk Assessment' recommended that the man should not be allowed to share a cell with another prisoner. The officer noted, 'totally unpredictable behaviour. Volatile and aggressive at times. States that he has abused drugs or alcohol and is currently dependent on one or both ... high risk.' The officer recorded, incorrectly, that the man had not previously been convicted of arson. At Durham, as at many prisons, reception documentation is completed on a 'question and answer' basis, the prisoner giving answers to questions put to him. In interview, the officer had no recollection of asking the man whether or not he had convictions for arson. He said that he would have put questions to the man and recorded his answers. The officer told my investigator that it was not his responsibility to check the accuracy of prisoners' replies to questions. As reception officer, he said that he had no access to records, either manual or electronic, and thought the checking was done 'subsequent to my dealings with an inmate'.
19. Details of all newly-arrived prisoners are recorded and, on the day following reception, administration staff cross-reference information to earlier sentences. They either update old records or initiate new ones on the prisoner Local Inmate Database System (LIDS). The work is usually completed by midday the day following a prisoner's reception. If the prisoner is received on a Friday, the record is complete by midday the following Monday. At that point, in theory, all significant new information and their previous history is recorded and available to those who are authorised to see it. In practice, the completeness of the information relies on both the system in place and the diligence of those required to record information. In the man's case, although the LIDS data sheet gave information (known locally as 'markers') in respect of violence, use of weapons,

likelihood of trying to escape, use of drugs, use of alcohol and likelihood of suicide or self harm, there was no mention of arson either through criminal conviction or in prison. The system for entering information on LIDS relied first on staff sifting and recording details of earlier criminal history, and secondly upon them submitting Security Information Reports (SIRs) when prisoners were involved in incidents within the prison. The incidents in the prison in 2004, when the man started fires, led to his being charged under prison disciplinary rules but staff did not complete a SIR. The effect was that the details were not recorded on LIDS. Durham's Governor has since issued an order to ensure that details of serious incidents are recorded on SIRs and subsequently entered on LIDS.

20. Prisons have access to information held on the Police National Computer, (PNC). Durham is one of a limited number of prisons to have their own terminal in the prison. This enables them to print PNC information about those prisoners who have previous convictions, rather than rely on the information being forwarded by police. This information is not retrieved on the day a prisoner arrives. The information is usually printed about five days following reception. The man's printout consisted of nine pages and was dated 20 June 2005, seven days after his arrival and five days after his death. Together with 'warning signals' for violence, mental health issues and drugs, it showed details of past convictions including two of arson, the first in October 1999 and the second in January 2001, both of which had attracted custodial sentences.
21. A Registered Mental Nurse (RMN) conducted the health screening part of the reception process and noted that the man was concerned about his own mental health, had been using benzodiazepines daily, had previously self harmed and said that he might do so in the future. He had several injuries, occasioned before he arrived at Durham, none of which required treatment. The RMN recorded, 'History of self-harm and mental health issues. The man at present is elated in mood and unsure of his feelings.' The RMN admitted the man immediately for observation as a patient to the prison's healthcare centre. He also opened a F2052SH document (suicide and self-harm process) identifying his fears that the man might attempt suicide or self-harm. The opening of the F2052SH set in train several formal processes, including intensive checks and assessments of the man's condition. Under the heading, 'What do you think can be done to help the prisoner?' The RMN wrote:
 - '1) Admit to healthcare
 - 2) Refer to CPN
 - 3) See Medical Officer (MO) re medication
 - General support as per support plan.'
22. The man was allocated room H2-05 in the healthcare centre. He asked when he would get his medication, especially diazepam, and then slept for a while. During the afternoon, an RMN of South of Tyne and Wearside Mental Health NHS Trust sent a fax for the attention of prison healthcare staff. The fax gave details of the

man's consultant in the community, identified his prescription drugs and, significantly, identified that the man had threatened to kill himself if remanded in custody.

23. The duty doctor visited during the evening. The man was asleep. The medical record note is not clearly written but appears to say, 'Fast asleep, did not waken. Written for diazepam 10g tonight and 5g am. Confirm medication with GP.'
24. The man awoke later and played pool during a healthcare recreation period. The last evening note at 8.45pm shows him as appearing to have settled well in the healthcare centre.
25. A Principal Officer (PO) was night shift manager and visited the healthcare centre at the beginning of his shift. The man was agitated and asking for medication. The PO spoke to him and he appeared to settle down. The 'Prescription and Administration Record' chart records that at 10.30pm a nurse administered 10mg diazepam and 1g paracetamol.
26. At 11.30pm the man threatened staff, saying that the nurse had taken his cigarette lighter. The PO searched for the lighter and found it in the man's sock. It was over an hour later that the PO left the healthcare centre, having talked to the man who was much calmer. But at 3.00am the PO was called again to the centre as the man had broken furniture and was sitting on the bed. He had a table leg in his hand. When the PO asked him what he was doing, the man replied 'I don't know, just sitting.'
27. Again the PO spoke to the man. He handed the table leg over and the PO cleared the cell of splinters. He sat on the bed with the man and talked to him. When the PO left, the man was smoking a cigarette. The PO had not got very far when he was called back. The man had now broken the cell light and thrown it through the observation hatch in the door. The PO made the cell safe. The healthcare centre was fully occupied and there was no other accommodation available for the man. The assistant night manager also spoke at length to the man who 'eventually settled and calmed himself'.
28. At 4.30am a nurse again administered 10mg diazepam and 1g paracetamol.

The morning of 14 June, location in the segregation unit

29. By next morning (14 June), the healthcare cell in which the man had spent the night was unusable. The healthcare centre is almost always fully occupied, and there was no accommodation available there for him.
30. The managing medical officer knew the man from his previous time at the prison and told my investigator in interview, 'the man had major mental health problems and possibly a personality disorder. I was aware that in the past he had been

sectioned under the Mental Health Act and there were indications that he was paranoid schizophrenic.’

31. The doctor asked for up-to-date NHS records and it is commendable that South of the Tyne and Wearside Mental Health NHS Trust responded immediately, sending facsimile records of the man’s recent medical history, together with details of the medication he was receiving before being sent to Durham. The doctor was therefore able to add the comprehensive NHS information to his own knowledge of the man.
32. The doctor read from the reception documentation of the day before that the man appeared elated, was concerned about his mental health and had made threats to kill himself if remanded to prison. He noted also that the man had said he had taken other drugs in addition to those prescribed. The doctor’s opinion was that the man should be transferred to the segregation unit where staff also knew him. The segregation unit is quiet and well-ordered, and he assessed that the man would benefit from the calmness and high staffing levels. The doctor believed that the segregation unit staff would have time to attend to the man’s needs, and to manage his outbursts. Segregation unit staff were to continue the F2052SH process.
33. In his written statement to the police and in interview with my investigator, the doctor summarised his judgment that segregation was the best place for the man as follows:
 - The man required a higher level of supervision by discipline staff than is practicable in healthcare.
 - The doctor felt he would benefit from a period of relative seclusion in a quiet area where he had not caused a disturbance.
 - The doctor believed the man to be a risk to staff and other patients because of his disruptive and violent behaviour. He had previously damaged his healthcare cell and it was now a danger to him as he had made rough surfaces and sharp edges.
 - To the best of the doctor’s knowledge there was no other appropriate location in the prison.
34. The man went willingly to the segregation unit and arrived there at 8.45am. A Senior Officer raised a standard Prison Service form known as a Segregation Safety Algorithm. That form requires staff to assess and make decisions about the appropriateness of segregation for a prisoner and requires a doctor or qualified nurse to complete some parts of it. The duty governor, or adjudicator in case of a prisoner segregated during a disciplinary hearing (adjudication), must authorise segregation before a prisoner can be segregated.
35. Special consideration must be given if a prisoner subject to F2052H is to be located in a segregation unit. Prison Service Order 1700 (PSO 1700) says:

'Prisoners on an open F2052SH should only remain in segregation in exceptional circumstances. A self harm case review takes place that same day whenever possible (up to a maximum of 24 hours). A Safer cell is used to accommodate a prisoner on an open F2052SH whenever possible. The use of overt CCTV should also be considered.'

36. A nurse completed the medical section and a Duty Governor authorised the man's segregation in cell 22. The SO completed a form 'Segregation History Sheet, Prisoner on F2052 Self Harm'. The second page of that form is headed 'Prisoner Risk Assessment for Segregation Unit'. The SO wrote on that page, having regard to the man's history and current disposition, that a senior officer and three officers should be present when his cell was unlocked. Under 'Type of furniture – Explanation if necessary', the SO wrote 'Moulded – Safer Custody Suite'.
37. The SO also wrote, 'Volatile, threats to kill, violence, threats to staff, assault, weapons, escape.' He recorded the risk factors as 'Threats to staff, very unpredictable, treat with extreme caution. Previous assaults on staff. Mental Health issues.' Under the heading, 'Agreed systems of work for managing risks', the SO wrote:
 - 'The cell should be unlocked by a Senior Officer plus three staff
 - He should use paper plates
 - His cell would be equipped with moulded furniture.'
38. There was no mention of arson, either the man's history of criminal convictions or of setting fires in prison.
39. Cell 22 was designated a 'safer cell'. It had moulded furniture and a CCTV camera monitored activity within the cell and relayed pictures to the wing office. The man did not want to stay in this cell. He told an officer who was detailed to locate him that he had been in it on an earlier sentence and that it brought back unhappy memories. The locating officer moved the man to cell 17, also a 'safer cell'.
40. There was one important difference between cells 22 and 17. Whereas cell 22 had moulded furniture, cell 17 had cardboard furniture. Because of the nature of its construction, cardboard furniture does not lend itself to being used as a weapon and was used at Durham where prisoners were known to be indiscriminately violent. The cardboard furniture was 'second generation' and an improvement on its predecessor in that it was coated to minimise the chances of it catching fire. In Prison Service Order 1700, the Prison Service required a detailed risk assessment in cases where the use of cardboard furniture was contemplated. Specifically:

- 'The use of Cardboard Furniture must be authorised by not less than an Operational Manager F¹.
 - The use of Cardboard Furniture must be risk assessed as part of the overall management of the prisoner. A timescale for its planned removal must be prepared.
 - The use of Cardboard Furniture and the timescale for its planned removal must be reviewed by no less than an Operational Manager F.
 - The use of Cardboard Furniture must not be routine, but must be risk assessed on each occasion.'
41. Nobody conducted a risk assessment for the man to move into cell 17. The locating officer did not consider assessing the risk. He told my investigator that the man was volatile and aggressive, upsetting the other prisoners. The segregation unit held difficult and disturbed prisoners and the locating officer saw getting the man settled as a high priority. In any case, risk assessments in respect of allocating prisoners to cells with cardboard furniture must be made by a manager not below the grade of Operational Manager F. Had the locating officer considered a risk assessment, neither he nor any member of segregation staff was qualified to conduct it. They would have had to call upon a manager of appropriate grade. For example, the Duty Governor who had authorised initial segregation was a manager F and he could have considered whether or not it was appropriate that the man occupied a cell with cardboard furniture.
42. A female officer was on duty in the segregation unit. She told my investigator during an interview in March 2008, 'I saw Officer B and another officer locating and searching the man. I questioned whether or not he should have his lighter. They hadn't made any decisions about his lighter. I went to the SO's office and said to the SO, can he keep his lighter? The SO said, "Yes." My investigator asked the officer what had led to the question. She said, 'I always do.'
43. My investigator asked if there was something special that had led to the question about the man. The officer said, 'he was disruptive and the worst prisoner I've ever looked after. I knew also that he had set fire to the healthcare centre on his last time in custody. I've known people have lighters taken from them in the past when they have a history of fire-setting. I would have asked the question about anyone, but maybe because of prior knowledge, I remember questioning about him.' My investigator asked if the officer thought to warn the SO about the man's record of setting fire and, had she done so, whether or not that would have been useful information. She said, 'I think you're questioning if my information to the SO was sufficient. He just said "give it to him". I don't know if he would have taken a different view if I'd told him that the man had previously set a fire. As far as I was concerned, it was common knowledge that the man started fires. I didn't tell anyone specifically. I believe many people would have known. I'm surprised that people didn't know. I was assuming that all staff, including the SO,

¹ An experienced middle-manager, often referred to in prison as a 'governor grade'.

would know this prisoner. I was a little surprised that the SO let him have it but I didn't question it.'

44. In April 2008, my investigator interviewed the Senior Officer (now Principal Officer) and asked if he knew the man or the history of his conduct in prison. The SO (now PO) said he had no prior knowledge of the man. My investigator asked what information he had to hand when locating the man in the segregation unit. The SO/PO said he first took account of the man's demeanour, which was agitated and 'beyond reason', and, secondly, in accordance with standard practice, he telephoned the security manager for a briefing which identified the warning 'markers' attached to the man's record. Although violence and drug use were recorded, there was no mention of arson. The SO/PO said that he decided to locate the man in a safer cell and to ensure staff were present in numbers sufficient to ensure their safety, and that of the man himself, when his cell was unlocked. The SO/PO did not recall the officer asking him if the man could keep his lighter. He said that she might have done so. He was sure, however, that had the officer mentioned to him the man's previous history of fire-setting, he would have taken the lighter from him. The SO/PO said, given the information he had, it was reasonable to allow the man to keep his lighter.

The daytime and evening of 14 June

45. A doctor visited the man in mid-morning and saw him again during the afternoon. A note in the unit file shows that the man took the medication which had been prescribed for him, and there were periods of calm. The man asked the doctor if he would also prescribe cod liver oil tablets and the doctor said he would. The man was noisy, but not distressed. The relative peace did not last very long and the unit notes show that the man again became demanding and noisy, allegedly making threats to assault a member of staff and constantly ringing his cell bell. As he was also subject to the conditions of F2052SH, staff were required to visit and interact regularly. In reality there was no need to remind staff to keep a special watch on him as his behaviour meant he received constant attention. He had run out of tobacco and, as smoking was the only thing that appeared to have a calming effect on him, from time to time staff gave him cigarettes and tobacco. Although a formal review was due to take place not later than the next day, events overtook the process and the man was admitted to a hospital in the community early the following morning.
46. The chaplain visited the man during the afternoon. He knew him from a previous sentence. He told my investigator that during his visit to the man staff were 'kind and decent – calling him by his first name'. The chaplain sat in the man's cell, just the two of them with no staff present. He described the man as 'anxious but calm' and said that he talked about his new girlfriend. The chaplain said he did not feel threatened. He stayed for about 20 minutes. He returned to the segregation unit later that afternoon. The man's door was open. Two members of staff were talking quietly to him. The chaplain said this characterised the unit

as a quiet place where prisoners often felt better than they did amongst the busy, often noisy, life of the main prison. The man asked for a rosary and newspapers. The chaplain thought the request unusual and, although the man was not registered as a Roman Catholic, he decided to get the rosary and take it to him next morning.

47. During the evening the man was still upset, but following a long conversation with the SO/PO he appeared to be settled for the night. The SO/PO promised the man that he would see him again the following day and together they would find a way forward. Other staff in the segregation unit also thought that he seemed settled.

The late evening of 14 June and night of 14/15 June

48. At about 9.00pm, the officer who was on duty in the segregation unit called the night manager, a Principal Officer, as the man had used paper to block the cell observation panel. He was also shouting through his cell window, making threats and demands. The Principal Officer, together with assistant night manager, went into the man's cell and talked to him. He calmed down but this state did not last long and the pattern continued until 2.30am, the night managers making several further visits. At 2.30am, the man again obscured the observation panel and the camera inside the cell. The managers visited again and after about an hour the man unblocked the camera and the door panel. They gave him 'a couple of cigarettes under his door and he seemed calmer'.
49. However, the managers were called back again at 5.45am, by which time the man had pulled the taps from his wash basin and smashed the glass in the cell door panel, throwing debris through the hatch in the cell door. He was offering to fight anybody who entered the cell. The Principal Officer cut off the water supply in order to prevent flooding and advised staff to stand well away from the cell door to avoid being injured by the glass and debris that the man was throwing through his door panel. The PO observed in his report, 'There was no reasoning with him now. He was intent on doing as much damage as he could for as long as he could.' The PO assessed that to locate the man in another cell would simply give rise to an opportunity for more damage. He left the area and handed over to the day manager, another Principal Officer, who had arrived at 6.30am to take over the operational management of the prison.

The morning and daytime of 15 June

50. The morning shift was due on duty in the segregation unit at 7.00 am. Staff started to arrive at about 6.45 am. The first officer, who was the first of the day shift staff to go to the unit, was warned by another officer that the man had damaged his cell and had items that could be used as weapons. The first officer took up a position opposite the man's cell. Initially the light was on but then it went out. At about 7.05am, the second officer saw smoke coming through the door hatch. He raised the alarm for fire and ambulance emergency call out.
51. The Principal Officer from B wing arrived, also at 7.05am, and took charge. Another Principal Officer, who was the day Orderly Officer, also responded to the fire alarm and went to the segregation unit. Both knew about the man's activity during the night. The PO day orderly officer instructed staff to dress in protective clothing, known as Control and Restraint (C&R) equipment. According to his statement of 16 June to the Governor, 'By the time the (C&R) teams were ready the Fire Brigade had arrived and the PO briefed them.'
52. The statement to the Governor of the first day shift officer to arrive on duty is detailed and graphic. It is worth reproducing here in full:

'I started duty at approx 06.15 hours on 14 [misdated – should read 15] /06/05. I was informed by an officer not to walk past cell 17 as the man had smashed his observation panel and had been throwing various items through it. At this point the man had his cell bell on and was shouting. I positioned myself in the adjudication room facing cell 17 and started to complete routine paperwork. At approx 0700 the man was at his door and I observed him looking through the broken observation panel. At this point he had his light on. A couple of minutes later the cell was in total darkness. I thought he had put his mattress against the door. At approx 0705 I noticed smoke coming out of the broken observation panel and immediately raised the alarm by phoning the ECR (Emergency Control Room). Staff arrived on the scene very quickly. An officer put the fire hose through the observation panel. I was informed by the PO to put C&R equipment on as we knew he had destroyed parts of his cell prior to the fire and could have weapons. The fire brigade arrived and the door to the cell was opened. Officer B had the shield and I along with another officer was behind him. As soon as the door was opened we were hit with a wall of black smoke and it was impossible to see anything. Officer B entered the cell and I followed. I immediately realised after one breath of the fumes that it was impossible to stay in the cell. At this point I could not see Officer B so I reached in and I felt his back. I grabbed a hold of him and pulled him backwards out of the cell. Once out of the cell we still stood in the door area while staff shined in torches and the fireman sprayed the water hose. Whilst there, Officer B noticed a trainer under the bed (the trainers were bright yellow). It was at this point that we again

entered the cell and realised that the man was lying face down under the bed. Myself and Officer B dragged the man out of the cell into an area where the medical staff could perform their actions. I then went outside to get some fresh air. I could hardly see and was physically sick due to the smoke. Myself and Officer B then went to the University Hospital.'

53. The Senior Officer on duty in B wing also heard the radio alarm and went to the segregation unit. An officer told him that the man might have a weapon and to be careful, particularly not to walk in front of the cell door as the hatch was broken. The SO told my investigator that there was glass and other debris on the floor of the landing and smoke was building up. He helped an officer to unroll the fire hose and inundate the cell with water. He described how he and others made and aborted a rescue attempt, having been beaten back by smoke, and were told by fire officers that the fire was still burning.
54. Officer B told my investigator how he formed a rescue team with two other officers. He said that they were in the cell for 10-15 seconds when they were overcome by smoke. Officer B said that visibility was 'zero' and that an Officer pulled him from the cell.
55. The Emergency Log held at the prison showed that the fire brigade was called at 7.06am and arrived at the prison at 7.11am. An ambulance was called at 7.18am and arrived at 7.22am. The fire brigade officers determined that the fire was still burning and that it was unsafe for staff to enter the cell.
56. The firefighters, wearing full breathing equipment, eventually put the fire out. There are no timed entries in the log but it is probably right to assume that it would have been some minutes before a firefighter, with the help of two prison officers, entered the cell, found the man lying under the bed and pulled him out.
57. A Nurse told my investigator that on the morning of 15 June she was just about to complete her night shift when, at about 7.05am, she heard through a general radio alarm of a fire in the segregation unit. The Nurse was designated 'first medical response' and went to C wing clinic to collect an emergency bag. She then went to the segregation unit. The Nurse estimated that she was in the unit within three to four minutes of hearing the alarm. Once there, she saw several officers in attendance. She concluded that when she gained access to the area and to injured parties they would need oxygen. She opened the emergency bag and found that the oxygen mask was missing.

The Governor should remind clinical staff of the importance of ensuring that emergency equipment is complete and ready for use.

58. The Nurse went to B wing clinic and collected a mask. She estimated that she was back within two minutes. She said that a Principal Officer appeared to be in charge. There was smoke on the landing and water on the floor. She could not

at that stage do anything to help and she waited near the man's cell. She attached an airway to the oxygen cylinder, ready to move quickly when it became possible. At that point she said that she heard 'a desperate voice calling "I can't breathe."' She said, 'I'm sure it was repeated. I assumed it came from the man but I can't rule out that it came from a member of staff as several officers were treated for smoke inhalation.' The Nurse said that the fire brigade arrived, complete with breathing apparatus, and the Principal Officer gave an order for staff to enter the cell. Together with fire brigade officers they brought the man out of the cell. The Nurse and a member of the fire brigade started resuscitation. The firefighter performed chest compressions while she used the airway. She checked for a pulse but found none. She said that an ambulance crew arrived and took over from the firefighter. She continued to attempt to revive the man during the journey to the prison gate. Another Nurse took over from her and accompanied the man to a local hospital.

59. A Doctor also went to the segregation unit. Paramedics had taken over the man's treatment and were preparing for his removal to the hospital. The ambulance left the prison at 7.44am.
60. Two Principal Officers and a number of other officers were also taken to the hospital where they were treated for the effects of smoke inhalation.
61. All the members of staff who were involved submitted statements to the Governor. They are all broadly consistent with those I have described in detail.
62. The then Governor arrived at the prison at 8.15am. Having satisfied himself that the incident contingency plan had been actioned, and that the man's next of kin were being contacted, he held a 'hot de-brief' meeting to examine what had happened, what had been done and whether or not lessons could be learned immediately. He was in regular contact with the Senior Officer in charge of the hospital escort, who updated him on the man's condition and of the staff who were there for treatment. One member of staff, a Senior Officer, had to receive oxygen to help with his breathing.
63. Senior police officers attended the prison during the morning. The man's cell was sealed so that forensic examination could take place. The Fire Brigade notified HM Fire Services Inspectorate, Crown Premises Inspection Group (CPIG), of the serious fire.
64. At about 10.00 am, having spoken to the hospital chaplain, the prison chaplain visited the man. Although the man was not registered as belonging to a religious denomination, the chaplains thought it appropriate to administer the Last Rites to him. They did this jointly and then prayed together. The prison chaplain said he was shocked to see so many staff at the hospital waiting to be treated for the effects of smoke inhalation. He also questioned why staff were needed to guard the man, but was told by hospital staff that they preferred this arrangement,

though not for security reasons. Two members of staff stayed outside the man's door.

65. The chaplain met the man's mother and grandfather at about 12.20pm. He thought that they were upset and angry. They wanted to know above all why the man had a lighter in his cell. The chaplain said he did not know whether or not the man had a lighter. He went with the man's family to see the consultant who said the man was very ill and his ventilator would be turned off at 2.00 pm to see if he could breathe on his own. The consultant was not optimistic. The man's mother told the chaplain that she wanted to see the prison Governor.
66. The Governor went to the hospital where he met the man's family. He told my investigator that they were upset and angry and had said that the prison was to blame for the man's condition. They asked for details of what had happened earlier in the day. The Governor said that he explained what the establishment had done to care for the man from the time of his arrival. He also told the family that prison staff were being treated in the Accident and Emergency Department of the hospital, following their efforts to save the man. The man's mother told the Governor that it was difficult to get from their home to the hospital, and he said they should use taxis and charge the cost to the prison. The Governor said that the conversation was difficult. (Having regard to the circumstances, this is not surprising.) He said, however, that the man's family were grateful for his offer to pay their travel expenses to the hospital. He concluded his meeting with the family and they returned to the ward.
67. The Governor went to Accident and Emergency to check on the condition of the staff under treatment, and then returned to the ward. By this time the man's stepfather had arrived and the Governor spoke to him. The Governor said that, as with his earlier conversation, the family directed their anger at the prison. He stayed at the hospital until, at about 2.40pm, life support was withdrawn from the man. Shortly after that, the three members of the man's family left the hospital. The Governor was informed that the man had died at about 2.50pm. He took appropriate action, initiating the prison's contingency plan, and he put in place all the necessary formal processes.

EVENTS FOLLOWING THE MAN'S DEATH

68. The Governor spoke later to the man's sister by telephone. He told my investigator that the conversation was a long one and he recalled that it was difficult. He said that he gave as much information as he had to hand. He said that the man's sister was angry and, in his view, asked the same questions over and over again. He felt that he was as understanding as possible, but the conversation ended after about an hour and both parties were deeply dissatisfied. The Governor said that he felt he had done his best to explain how the man had died. When my investigator and family liaison officer visited her, the man's sister said that the Governor had been difficult and eventually sarcastic when he said they had been over the ground again and again and he could not add to what he had said.
69. The Governor wrote on 23 June to the man's mother, again offering his condolences and informing her that he and a senior colleague had spoken to the man's sister. In the letter he offered to pay the man's funeral expenses and also told the man's mother that the Prisons and Probation Ombudsman would conduct an independent investigation into the man's death and the standard of his care at Durham. The letter also gave details of voluntary organisations who provide support for bereaved families.
70. The Home Office Pathologist for the North East of England conducted a post mortem examination on 16 June 2005 at University Hospital, North Durham. He found that the cause of death was, '1a: Carbon Monoxide Poisoning, due to 1b: inhalation of smoke.' The man's family expressed concern to the coroner's officer in respect of damage to the man's teeth and his bruising as the post mortem report had not mentioned damage to the man's teeth. The coroner ordered a second post mortem examination, which another doctor performed on 29 June at the same hospital. The doctor's findings were consistent with those of the Home Office Pathologist. The doctor had no doubt that the inhalation of smoke and fumes from the fire constituted the underlying cause of death. The doctor found that the man had probably sustained fatal brain damage before possibly ingesting water.
71. The doctor found that the man had suffered a lethal level of smoke inhalation and suggested that drowning did not contribute to his death. Although the man had ingested water, the doctors concluded that he died from the toxic effects of carbon monoxide caused probably through his destroying and setting light to the cell furniture which, although coated with a fire retardant preparation, appeared to have been combustible when broken, possibly shredded. Both post mortem reports noted other injuries which were healing and did not contribute to the man's death. Fresh injuries were consistent with the removal from his cell and from attempts to resuscitate him.

72. A toxicological examination was conducted on 16 August 2005 at the Forensic Science Service Laboratory, Chorley. It found that the man had inhaled carbon monoxide gas prior to his death. The examination also established the presence of cannabis, diazepam and possibly sertraline (a medicine used in the treatment of depression).
73. The man's family visited the prison and went to the cell where he had died. They were upset that the cell had been cleaned prior to their arrival. I asked the Governor about this. He said that staff thought it would be distressing for the man's family to see the cell flooded and scorched and so they had taken the initiative and cleaned it. I have found in other investigations that staff have cleaned the cells prior to the family visit and do not doubt that this is done with the best of intentions. However, great care should be taken to establish if it is actually what the family would prefer.

The Governor should, where possible, ask families if they would prefer to see the cell in the condition it was in when the prisoner died. In addition, the Prison Service's Safer Custody and Offender Policy Group may wish to remind jails of the sensitivity of this matter via its publication, Safer Custody News.

CLINICAL REVIEW

74. A doctor conducted a clinical review of the standard of medical care provided to the man at Durham. The review details the man's previous medical and social history and identifies the early problems in his life and his history of mental illness, together with inpatient and outpatient treatment.
75. The doctor comments that, at the time of the man's arrest, he was examined by four police surgeons and the police unit Registered Mental Nurse, none of whom could identify psychiatric symptomatology that would justify admission to hospital.
76. The man's physical injuries were seen and recorded by prison healthcare staff on his reception to Durham and they are detailed in the clinical reviewer's report. The injuries, although not serious in themselves, were considerable and varied. His family are concerned about how these injuries were caused, and they have asked their legal representative to investigate.
77. The clinical review notes that the man's mental health problems were identified at Durham. Although he seemed elated, he said that he might harm himself and he was placed on a suicide and self-harm watch. The report notes that the man was seen on 14 June by a doctor, and although he was not 'expressing any intent to self-harm, he was clearly not well'. The doctor's notes say, among other things, 'allow to settle and then review'.
78. The clinical reviewer notes that prison healthcare staff contacted the Assertive Outreach Team in the area and the Personality Disorder Team. He says, 'It was helpful to have the psychiatric record from the Assertive Outreach Team. This had been requested by HMP Durham and provided by the Trust.'
79. The clinical reviewer concludes that, in his opinion, everything was done to manage the man appropriately, and that the outcome did not reflect any lack of care by the clinical team. He has made no recommendations.

HM FIRE SERVICE INSPECTORATE (CROWN PREMISES INSPECTION GROUP)

80. HM Fire Service Inspectorate, Crown Premises Inspection Group (CPIG), work closely with local Fire and Rescue Authorities, as both parties are interested in the risk posed within premises. CPIG enforce legislation and, to inform their risk prioritisation, benefit from intelligence gathered by Fire and Rescue Authorities whilst responding to emergency incidents. Fire and Rescue Authorities need to gain information to inform their local risk management plans and the intervention strategies of firefighters. They consult CPIG as a matter of course when a serious fire has taken place on Crown Premises. In the case of the man's death, which was clearly a serious matter, CPIG visited HMP Durham. Their authority at the time only extended to the safety of prison staff, although CPIG told my investigator that this will change in the near future when everyone, including prisoners, comes within their remit.
81. My investigator met a representative of CPIG at HMP Durham, and he readily shared all their information. CPIG's overriding view of the fire which caused the man's death coincides with that expressed in the report, dated 1 February 2005, of their inspection in January of that year. I identify below the main concerns listed in their report to the extent that they impact on the man's death:
- Insufficient attention to risk assessment.
 - Areas from where escape routes were unsatisfactory in case of fire.
 - Lack of automatic fire detectors in many areas, including cells and landings.
 - Lack of fire extinguishing systems in cells (sprinklers and watermist).
 - Only 35 per cent of prison staff trained in fire procedures. None of them were governor grades.
82. CPIG were concerned at the lack of training of staff who attended the fire in the man's cell. Their view was that staff had done their best but, without either adequate training or personal equipment to enable them to operate safely in their attempts to put out the fire, they were vulnerable in the extreme. CPIG pointed to the fact that many staff had been affected by smoke inhalation and treated at University Hospital Durham, and that one had required the administration of oxygen.

NATIONAL OFFENDER MANAGEMENT SERVICE (NOMS), TECHNICAL SERVICES

83. In November 2004, following the disbanding of the Fire Safety Section at the Prison Service, responsibility for Prison Service fire safety policy passed to Property Services Group (PSG) which, in April 2005, transferred to NOMS and joined the Home Office. (Since that time, NOMS has been restructured as an operational agency including the Prison Service and comes under the umbrella of the Ministry of Justice.)
84. On 2 February 2006, my investigator met the Head of Technical Services . My investigator asked the Head of Technical Services, amongst other things, about the circumstances in which cardboard furniture was still in use (cardboard furniture had, for some years, been the subject of discussions within the Prison Service about the balance between its dangers and benefits). The Head of Technical Services provided a written reply, dated 24 March 2006. It included the following:
- ‘The senior advisor on fire contingency planning and analysis for the Prison Service from 1999 to 2004, wrote, on 1 May 2003, to Governors alerting them to the fire risk presented by the furniture and advised them to consider:
- Removing the furniture from use.
 - Removing any source of ignition from prisoners.
 - Increasing supervision to ensure early detection of fire.
- ‘Following discussions with the manufacturer of the furniture, a new treatment process, believed to minimise if not eliminate the danger, was introduced. The new cardboard furniture was covered in a blue coating. By January 2004 though, it became clear that the new process had not eliminated the risk of combustion and the senior advisor wrote to the then Deputy Director General of the Prison Service who, in July 2004, wrote to Governors, endorsing the senior advisor’s letter of 1 May 2003 and adding a fourth condition for the use of cardboard furniture:
- ‘Where the use is maintained action taken to mitigate the risk should be recorded.’
85. Prison Service Order 1700 lays down the conditions and risk assessments, outlined above, under which cardboard furniture may be used.

ISSUES

The man's criminal history of arson and fire-setting in prison

86. The man had two previous convictions for arson. In October 1999, he was sentenced to six months in a Young Offenders Institution and in 2001 he was sentenced to four months. This information was available to HMP Durham at the time he was remanded in custody on 13 June 2005.
87. The man had served two previous sentences in Durham and was known by some members of staff there. Durham staff had learned to treat the man carefully. He was six feet five inches in height, and they found him difficult to manage when he became violent. On two separate occasions during 2004, he had used his lighter to set fire to a plastic plate and a mattress in a cell.

Staff knowledge of the man

88. On earlier sentences the man was subject to many disciplinary reports including one, in 2004, for assaulting a member of staff. On a different occasion, he was charged with attempting to stab a nurse. The charge was, as with a number of his disciplinary reports, abandoned at a Governor's disciplinary hearing. Records do not show why some of his charges were abandoned.
89. Some members of staff remembered the man from his previous time at Durham. The prison doctor knew him and an officer knew him well. She remembered his lighting a fire in the prison. Another officer who said he knew the man from two previous sentences, described him as the most volatile, unpredictable and violent prisoner he had met in 22 years. Other staff said they did not know him. All, however, identified from the moment he arrived on 13 June 2005 that he needed careful handling and special treatment in order to avoid him hurting himself or others.

Information on Local Inmate Database (LIDS) and the Security File at Durham

90. The man's LIDS record, under the heading 'View Inmate Details, LDEE02/01' showed under sub-heading 'Security Remarks':
 - 'INFO', VI [violence] WE [weapons] ESDR [escape potential and drugs] AL [alcohol] SH/SU [self harm and suicide].'
91. There was no warning for arson and there was no mention that the man had previously set fires in Durham. My investigator interviewed the security manager and three other members of his department. He asked why, given what was known about the man, no warning about either arson convictions in court or fire-setting in prison appeared on LIDS. The manager said that, at the time of the man's reception in 2005, it was not customary for previous convictions to

automatically lead to warnings on prison documentation. For example, nearly all prisoners had previous convictions, some of which were for offences of violence, drug use and arson. It was invariably the case that staff would look at the person and decide whether or not criminal behaviour was an indicator of likely conduct in prison. To write routine warnings of every prisoner who had previous serious convictions would be to devalue the process which was meant to alert staff to how a prisoner might behave in prison.

92. The situation was more complicated in terms of the procedure for entering warnings on LIDS. The sub-heading 'Security Remarks INFO' recorded information gathered as a result of Security Information Reports (SIRs) submitted by staff. Staff submitted SIRs when they received intelligence that prisoners or staff might be engaged in activities that breached good order and discipline. SIRs were also submitted when suspicious activity was reported but not brought to adjudication. For example, a prisoner might be injured but refuse to name his assailant or prisoners could be seen in groups which dispersed when staff approached. Such activities might also be illegal, for example drug-trafficking, theft or violence. Information on an SIR would be evaluated and dealt with according to set criteria. If the information or proved activity warranted an entry on LIDS, the security department would enter the initials, VI for violence, WE for weapons, DR for drugs and so on. If staff needed more information than the headlines and were entitled to have it, the security department could disclose information from the security file.
93. At the time of the man's death, the system was only partially effective in that only the information on SIRs was entered on LIDS. If, as in the man's case, a prisoner set a fire within the prison, he would normally be charged and adjudicated on by a governor. This event and its consequences would not lead to an SIR and therefore would not be recorded as a warning on LIDS. Thus, unless anyone had personal knowledge, staff accessing LIDS would have an incomplete picture. There were other examples of incidents not being reported on SIRs. An audit conducted by the Prison Service Standards and Audit Unit in 2006 drew to the attention of the Governor the inconsistency of incident reporting. In a Notice to Staff dated 5 July 2006, the Governor identified the weakness of the system and instructed staff that details of all incidents should be submitted on SIRs. Had that system been in place at the time of the man's death, it is probable that details of his fire-setting at Durham would have appeared on his record through LIDS. When a Senior Officer asked for security information, he would have seen that the man started fires. He would then have had complete information to enable him to consider whether or not the man should have his lighter in his cell.

The Governor should review the arrangements for reporting and recording risks presented by prisoners, and should ensure that all information and records of incidents are transferred in an easily readable form to LIDS and other documentation.

The man's retention of his lighter

94. The man was well known at Durham and I have considered whether or not staff should have been aware of information, albeit available from different sources, that he was likely to start a fire.
95. In allowing him to have his lighter in his cell, the Senior Officer did so as a result of information available to him. He did not know of the man's propensity to start fires and the information he sought and obtained from the security department did not alert him to it.
96. An officer who knew about the man's fire-setting, asked the Senior Officer whether the man should be allowed to have the lighter in his cell, but told my investigator that she did not elaborate. She did not tell either the officers locating the man in his cell or the Senior Officer what lay behind her question.

The Governor should remind staff to be proactive in assessing whether or not prisoners should be allowed lighters and matches in their possession

Location, cardboard furniture and risk assessments

97. The Senior Officer assessed the risk when he located the man in cell number 22. This was a cell which had moulded furniture. However, an officer did not call for another risk assessment when he located the man in cell 17 which had cardboard furniture. In any case, neither the officer nor the SO were qualified to locate the man in a cell with cardboard furniture. The risks were well-known to the Prison Service and only a manager of at least Grade F seniority was qualified to risk assess and locate a prisoner in a cell containing cardboard furniture.

The Governor should remind staff of Prison Service Order 1700 and the requirement to assess risk when the use of cardboard furniture is contemplated.

A copy of Prison Service Order 1700 should be held and displayed prominently in the segregation unit.

Short Duration Breathing Apparatus (SDBA), Prison Service policy and staff access to smoke-affected areas

98. The Prison Service introduced SDBA some years ago as a means of enabling staff to put on a 'smoke hood' and enter safely a smoke-affected area, typically a prison cell. The equipment was not meant to enable staff to fight fires or to do anything other than rescue a prisoner who might be unable to effect his own escape.

99. I understand that the equipment was not popular from the outset. Although the Prison Service introduced training and periodic refresher training regimes, many officers and their trade union have felt that the operation of SDBA is fraught with problems.
100. In 1996 the Prison Service issued Instruction to Governors (IG) 34/1996. That instruction required the Governor of each establishment to make risk assessments against set criteria and decide whether or not it was appropriate to use SDBA in smoke incidents.
101. My investigator contacted the Health and Safety and Fire Safety Manager in the Prison Service. The HS&FS Manager holds some statistics in respect of SDBA. In 2007, from an estate of 139 Prison Service establishments, 31 had fully-maintained SDBA equipment. There are no records of the establishments which used the equipment as they did not submit returns, but he thought that only a few used SDBA and hardly any would have staff trained in sufficient numbers for night-time use.

Durham's local policy and practice for intervention in fire or smoke-affected areas

102. In accordance with the terms of IG 34/1996, Durham made its risk assessments and decided that the prison would not use SDBA. Two Governor's Orders identify the procedure staff must follow in case of cell fires. The first, number 03/05, published on 27 April 2005 and current at the time of the man's death, is headed CELL FIRES and says:

'This order advises staff of the procedures which are to be followed in all circumstances concerning cell fires:

- raise the alarm
- save life, evacuate the area
- fight the fire if safe to do so.

In the case of fire follow steps 1, 2 & 3 above:

- Evacuate the area at all times
- Inform the Control room no matter how large/small the fire
- Assess the situation and the severity of the fire
- Inundate the cell through the inundation point or the observation panel by smashing the panel if required
- Staff should continue to inundate the cell until the Fire Brigade arrive and take over
- Follow the above steps
- If the prisoner is visible through the observation panel and does not constitute a threat to staff, the door may be opened sufficiently to allow access for the prisoner. However this is only appropriate if

there are two officers present and the prisoner responds positively to instructions

- Immediately close the door and carry on inundation until the arrival of the fire brigade. Inundation may cease if the fire is extinguished but periodic checks of the cell should take place
- ***Under no circumstances are staff permitted to enter a cell that is on fire or smoke filled. This should be left to the fire brigade.*** (Emphasis in original.)

The order was signed by the Governor at the time.

103. All Governor's orders are subject to periodic, usually annual, review. Order 03/05 was superseded by Order 11/06 and published by the incoming Governor. Although some of its content matched exactly that of the 2005 order, there were two significant differences. The paragraph allowing staff to open a cell door providing that the prisoner's response was positive and that two members of staff were present was deleted from the 2006 revision. In its place, a new paragraph was inserted:

- 'Evacuate the occupants of the cell and to fresh air (if it is safe to do so) as quickly as possible.'

The paragraph ***Under no circumstances are staff permitted to enter a cell that is on fire or smoke filled. This should be left to the fire brigade*** was deleted in the 2006 revision.

The Prison Service should review the use and availability of SDBA and seek to introduce, at the earliest opportunity, a safe means of entry to smoke-affected areas to allow all staff to effect a timely rescue of those in danger.

CONCLUSIONS

104. The man had served sentences in Durham on three previous occasions. One officer told my investigator that she knew him, as did the managing medical officer. It is probable that other members of staff also knew him and the difficulty of ensuring his safety and that of those who had to look after him. On entry into HMP Durham, reception officers, healthcare staff and doctors acted with commendable speed in assessing the man's demeanour and the risk he presented of hurting himself or others. An F2052SH was opened and he was transferred quickly to the healthcare centre and prescribed appropriate medication. Healthcare staff sought and received records of the man's care in the community, including details of current medication. Both the request and the Primary Care Trust's (PCT's) response were commendably speedy and an excellent example of teamwork embracing those working inside and outside prison.
105. The man had two previous criminal convictions for arson. He had also set fires on two occasions at Durham, the last time being less than a year before he died. That information was documented and available to staff, albeit in piecemeal form. The recording and retrieval systems in place at the time did not allow consolidation and coherence of information. For that reason, I welcome the fact that, following the man's death, the Governor implemented measures to ensure that all incidents recorded on Security Information Reports become warnings on the Local Inmate Database.
106. During his first night, the man was angry and destroyed the contents of his hospital cell. Both the night manager and his assistant tried to help him get through the night by going into his cell, sitting on his bed and endeavouring to calm him. Their efforts reflect well on them as individuals and on the Prison Service as a whole, and I would be grateful if the Governor would draw my comments to their attention. They spent most of the night at the healthcare centre but next morning, in spite of their efforts, the man remained unsettled and the cell was unusable.
107. I believe that the prison doctor's decision that the man should move to the segregation unit was defensible in the circumstances, as was the Duty Governor's authorisation of continued segregation. The man could not stay in the main prison and could not be allowed to make more healthcare accommodation unusable. The doctor assessed that the segregation unit, staffed by a higher number of officers who were experienced in the care of unstable prisoners, could in fact be a place of safety for him. Although this proved tragically not to be the case, I do not think the doctor's analysis was unreasonable at the time it was made.
108. The senior officer who initially located the man in cell 22 conducted a risk assessment. However, the assessment was not repeated when he moved to cell

17, even though it had cardboard furniture. In my view, reasonable steps were taken to find out about the man but the security department did not identify his history of arson and fire-setting. It is therefore possible that, even if a second risk assessment had been undertaken, the result would have been the same. I presume that, in the immediacy of moving the man to a cell which he found acceptable, and confronted with his anger and frustration, the officers simply forgot to recognise the added risk of cardboard furniture. They wanted to get the man settled to a point where he was calm, for his own sake and for that of other prisoners on the unit.

109. I have learned that the use of cardboard furniture has been the subject of discussion within the Prison Service for some years. It has proved effective in preventing prisoners causing injury to staff and others, but it is often in shoddy condition and can undermine prisoners' sense of self-esteem. It also has a self-evidently greater risk in terms of firesetting than that presented by wooden or moulded furniture. The cardboard furniture has been made less easily combustible, but it remains flammable for which reason the Prison Service has issued detailed guidance on its use. Prison Service Order 1700 directs that the risk be assessed by a senior manager when staff are considering locating a prisoner. As I have said above, it is possible to see why segregation unit staff overlooked the risk assessment in respect of the man, but nevertheless it should have been carried out.
110. The risk from the cardboard furniture would of course have been reduced if the man's cigarette lighter had been taken from him. I do not wish to single out an individual officer but I must say that I find the female officer's actions perplexing. She was correct to ask her senior officer whether the man should be allowed to keep his lighter, but regrettably she did not make him or anyone else aware that the man had started a fire during a previous period in custody. She told my investigator that she thought many of her colleagues knew the risks the man presented and so did not elaborate on her simple question. Had the senior officer known the man's history, either from the officer or from the prison's records, I have no doubt that more thought would have been given to whether he should be allowed to retain his lighter.
111. I believe that, as the prison expected, the man was well cared and supported whilst he was in the segregation unit. The chaplain confirms that he was treated with compassion and understanding. Staff knew that his behaviour was beyond his control and tried to get him on an even keel even when he was angry and destructive for a second night.
112. It would appear that the man lit the fire at 7.00am on the morning of 15 June and an officer quickly saw the smoke coming from the cell. He raised the fire alarm and used a water hose to flood the cell. Other staff arrived and put on protective clothing. They obeyed Governor's Order 03/05, described in the previous

section of this report, which contained explicit instructions that no member of staff should enter a smoke-filled cell and must await the arrival of the fire brigade.

113. In the event, the firefighters arrived within six minutes of the alarm. One of them, who was wearing breathing apparatus, and three prison officers without such equipment, tried heroically to find and rescue the man. (The prison's policy of not using Short Duration Breathing Apparatus was consistent with the overwhelming majority of prisons at the time.) The prison staff were overcome by smoke and so withdrew. They went back into the cell when the fire officer assessed that it was safe to do so and then managed to pull the man from under his bed and out of the cell.
114. The man's family believe that staff should have known enough about him to have kept him safe. They are particularly angry that staff in the segregation unit allowed him to keep his lighter in his cell.
115. I am well aware of the dangers of hindsight, but both my investigator and I believe that the man's death was preventable. He was assessed as at risk of harming himself. Nevertheless, the information about fire setting was not communicated adequately and he was allowed to keep his cigarette lighter. Despite having the lighter in his possession, he was not properly risk assessed before he was located into a cell with flammable furniture. Finally, the absence of a safe system of entry meant that precious minutes were lost before prison staff were able to rescue him. However, I should say too that this report has also revealed great professionalism, kindness and indeed bravery on the part of staff at HMP Durham. In considering this report and disseminating my conclusions, I would ask the Governor to share that judgement as well.

RECOMMENDATIONS

1. The Governor should remind clinical staff of the importance of ensuring that emergency equipment is complete and ready for use.
2. The Governor should, where possible, ask families if they would prefer to see the cell in the state it was when the prisoner died. In addition, the Prison Service's Safer Custody and Offender Policy Group may wish to remind jails of the sensitivity of this matter via its publication, Safer Custody News.
3. The Governor should review the arrangements for reporting and recording risks presented by prisoners, and should ensure that all information and records of incidents are transferred in an easily readable form to LIDS and other documentation.
4. The Governor should remind staff to be proactive in assessing whether or not prisoners should be allowed lighters and matches in their possession.
5. A copy of Prison Service Order 1700 should be held and displayed prominently in the segregation unit.
6. The Governor should remind staff of Prison Service Order 1700, and the requirement to assess risk when the use of cardboard furniture is contemplated.
7. The Prison Service should review the use and availability of SDBA and seek to introduce, at the earliest opportunity, a safe means of entry to smoke-affected areas to allow all staff to effect a timely rescue of those in danger.

GOOD PRACTICE

1. The Healthcare/Suicide Awareness Form sent on 13 June 2005 to Durham prison by the clerk to Gateshead Magistrates' Court alerting them to the danger of the man harming himself.
2. The speed and thoroughness with which South of Tyne and Wearside Mental Health NHS Trust responded to Durham's inquiries about the man's health in the community.
3. The way in which both the night manager and his assistant repeatedly tried to help the man by going into his cell, sitting on his bed and endeavouring to calm him.

I must also commend those staff who entered the man's cell in the attempt to rescue him on the morning of 15 June 2005. I do not know if their actions have been formally recognised. If they have not, they should be.