The Parliamentary Ombudsman

Parliamentary Commissioner for Administration

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ACCESS TO OFFICIAL INFORMATION
The Disclosure of Information in relation to Deaths in Prison

Presented to Parliament Pursuant to Section 10(4) of the Parliamentary Commissioner Act 1967

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HC 342

Parliamentary Commissioner Act 1967

I am laying before Parliament under section 10(4) of the Parliamentary Commissioner Act this report which contains the results of two investigations (C.39/95 and C.993/97 with its supplement A.27/99) carried out by my Office into complaints against the Prison Service. There was a third investigation which, at the request of the family, I have decided not to publish.

All three investigations were initiated following the death of a prisoner in custody. All involved not only questions of maladministration but also the question of public access to official information, and in particular to information contained in the reports of the internal investigations carried out by the Prison Service immediately after each death. Access to that information had been refused to the prisoners' families and their representatives without reference to the Code of Practice on Access to Government Information, the operation of which my Office monitors. In each of the cases information contained in the internal investigation report was eventually disclosed to the family, although in the first case (C.39/95) disclosure was by means of the information contained in my report. In the latter two cases I recommended that the internal inquiry report should be disclosed. I am very pleased to see that, with effect from 1 April 1999, the Prison Service now intends to release information to relevant parties before any inquest in relation to deaths occurring in prison after that date. So far as information in internal inquiry reports relating to earlier deaths is concerned, I shall treat on its merits any complaint I may receive about a refusal to provide such information.

M S BUCKLEY
Parliamentary Commissioner
for Administration

March 1999

C.39/95 – Administrative failures and a refusal on the part of the Prison Service to release a report of an internal inquiry into a death in custody

Summary of case

Miss C, whose brother died shortly after being re-admitted into prison custody, complained that administrative failures within the prison contributed to her brother's death. The Prison Service (PS) completed an internal inquiry into the death of her brother and made several recommendations for improving prison procedures, but they refused requests for the inquiry report to be made public. The Director General of PS said, in reply to a Parliamentary Question, that it was not PS's practice to publish reports of internal investigations nor to make them available to the Coroner. The Permanent Secretary at the Home Office told the Ombudsman he understood PS's policy was not to release reports of internal inquiries because they were internal documents and because their disclosure could prejudice security in prisons; he went on to say that requests would be considered on an individual basis under the Code of Practice on Access to Government Information (the Code). The Ombudsman found a number of errors and omissions by prison staff when dealing with Miss C's brother; while he could not say whether his death could have been avoided if the correct procedures had been followed by PS staff, the failure to follow a recommendation that Miss C's brother be placed in a communal cell merited his strongest criticism. The Director General of PS apologised for the shortcomings on the part of PS and outlined the procedural improvements which had taken, or would be taking, place throughout PS. As to the refusal to release the inquiry report, the Ombudsman found that since the original requests were made PS had reviewed their position; they had decided that reports of internal investigations into self-inflicted deaths in custody would be made available to the Coroner but for reference, not as evidence: as such, they should not be made public. The Director General of PS continued to refuse to disclose a copy of the inquiry report saying that the policy was under review and that he could not prejudge the outcome. The Ombudsman found, however, that the inquiry report contained no information which had not already been disclosed to the family of the deceased. He upheld the complaint.

Full report

1. Miss C complained about the way in which HM Prison Service (PS) dealt with the affairs of her brother, Mr D, who died while in custody at HM Prison, Armley (HMP Armley) and that administrative failures within the prison contributed to his death. Miss C also complained that PS refused to release a copy of the report of their internal inquiry into her brother's death.

2. The investigation began in February 1995 once the former Commissioner had obtained comments from the Director General of the PS after the referral of the complaint by the Member. I have not put into this report every detail investigated by the Commissioner's staff but I am satisfied that no matter of significance has been overlooked.

Background

3. The procedures applying to the reception of prisoners into prison in 1993 were set out in PS Standing Order 1A and included specific requirements aimed at the prevention of suicide. On a prisoner's arrival a medical officer would assess whether the prisoner was regarded as being at risk of attempting suicide, order preventive measures, where appropriate, and make a full record of the assessment and any instructions given to staff. That assessment would, at the time of Mr D's admissions

to HMP Armley, have been carried out under Circular Instruction 20/1989 (see paragraph 4) which stressed the crucial importance of prisoners receiving a thorough health check on arrival in prison. It was for the manager of each prison wing to ensure that the medical officer's instructions were recorded in the wing observation book and that those instructions were carried out by staff. Standing Order 1A also required that the Governor, or a member of staff appointed by the Governor, should interview a prisoner no later than the day after reception and that prisoners be interviewed as soon as possible after reception by a probation officer.

4. Circular Instruction 20/1989 contained PS's strategy for the identification and support of those regarded as potentially suicidal. Those instructions provided indicators on the assessment of risk, which included previous suicide attempts or self injury, a history of psychiatric problems, depression, drug or alcohol abuse. If a prisoner was assessed as high risk or at some risk (the latter including cases where there were a number of risk indicators but no clear indication that the prisoner was feeling suicidal, or where the prisoner appeared anxious or sad but was not clinically depressed) a form F1997 should have been completed and passed to the manager of the prisoner's wing (paragraph 3). Staff who came into contact with prisoners on reception were advised to be alert to indications of risk and to respond promptly. Furthermore, all prison staff were held responsible for referring to the medical officer (by completing form F1997) any prisoner that showed signs of being at risk.

5. The medical officer may recommend that a prisoner be placed in shared accommodation. At the time of Mr D's admission to HMP Armley, that recommendation should have been recorded on form F1997 (if one had been completed), on the prisoner's cell card, in the register held in reception, in the observation book held on the prison wing and on the computerised Local Inmate Database System (LIDS). The entry in the wing observation book was dependent on an entry having been made on the prisoner's cell card. A list of the names of those prisoners for whom forms F1997 had been completed (paragraph 4) and who required shared accommodation was available from LIDS. PS initially told the Commissioner's staff that LIDS could not identify recommendations for shared accommodation when form F1997 had not been completed but later provided an extract from LIDS which showed that a 'CC' (communal cell) recommendation had been included on Mr D's record. Circular Instruction 20/1989 also advised that prisoners placed in shared accommodation because they were regarded as at risk should not be left alone unintentionally after the transfer or discharge of a cellmate.

6. Prison staff undertake patrols during the night at HMP Armley. 'Pegging' is an electronic method of recording visits to certain sites at set intervals. A prisoner who wishes to contact staff on patrol can push a lever from inside the cell which causes a metal indicator (known as a tally) to fall into a projecting position outside the cell. Staff on duty in the prison wings do not have routine access to LIDS and rely on the wing observation book for any special instructions about prisoners.

7. Probation officers working at HMP Armley do not routinely record telephone calls and keep a written record only of what they regard as crucial information. Information on security matters or details of a prisoner's self-harm would be made known to prison staff but other matters are divulged on a 'need to know' basis to respect the confidentiality of prisoners' affairs.

8. Under Standing Order 1A (paragraph 3) cash and property brought into prison by a prisoner will be taken from him as soon as possible and stored or sent out of the prison. At the time of Mr D's admission, prisoners newly arriving at HMP Armley were not given cash or canteen privileges for several days. All prisoners' mail is opened by prison staff to check enclosures but not all mail is read before it is passed on.

9. Under section 13 of the Coroners Act 1988 where, on application under the authority of the Attorney-General, the High Court is satisfied that because new evidence or facts have been discovered it is necessary or desirable in the interests of justice that an inquisition on an inquest previously held concerning a death should be quashed and another inquest should be held, the High Court may order another inquest into the death and quash the inquisition on the first inquest. The investigation of the commencement and conduct of inquests are not within the Commissioner's powers, as set out in the Parliamentary Commissioner Act 1967, and I refer to such matters only to put in context the actions of PS.

10. Under paragraph 3(v) of Part I of the Code of Practice on Access to Government Information (the Code), which came into force on 1 April 1994, bodies within the Commissioner's jurisdiction are obliged to release, in response to specific requests, information relating to their policies, actions and decisions and other matters relating to their areas of responsibility, unless that information is exempt from disclosure under one or more of the exemptions at Part II of the Code.

Investigation

11. **1993** Mr D was admitted to HMP Armley on 12 March 1993. The reception assessment completed by the medical officer recorded that Mr D had answered 'No' to the question, 'Have you ever been depressed, deliberately injured yourself or attempted suicide?'. He confirmed that he had taken drugs. The medical officer noted that he was 'not depressed, not suicidal'. Mrs B, Mr D's mother, said later that at that time she had contacted a probation officer working outside PS as she was concerned about a suicide attempt made by her son in 1992. That probation officer later told the inquest that was held into Mr D's subsequent death (paragraph 17) that he recollected that Mrs B had been concerned about Mr D's general lifestyle and that he had not understood there to be any concerns about self-harm. He said that when he had visited Mr D in prison on 22 March he not shown any sign that he intended to harm himself. That probation officer also told the inquest that he had been due to visit Mr D again after his subsequent readmission to HMP Armley (see paragraph 12) but, as it took a week and a half to arrange appointments, he had not had the opportunity to do so.

12. Mr D was released from HMP Armley on 2 April and was readmitted on 18 June. A prison officer noted on that occasion that, on entry to prison, Mr D had 'dashes' on his wrist. (Mrs B later told the Commissioner's staff that Mr D had cut his wrists some weeks earlier and scars were evident; that was confirmed by the pathologist at the subsequent inquest.) The same medical officer that had seen Mr D in March undertook the reception assessment. Mr D answered 'Yes' to the question, 'Have you ever been depressed, deliberately injured yourself or attempted suicide?', and said that that had been in 1992. He also confirmed that he had taken drugs, most recently three days earlier. The medical officer noted that he had 'felt depressed' in 1992 but was 'OK now'. She further noted that Mr D was not suicidal but recommended 'CC' (that he be located in a communal cell); she did not complete form F1997 (paragraph 4). Mr D did not tell the medical officer that

his general practitioner (GP) had referred him to a consultant psychiatrist and that he was waiting for an appointment. (At the inquest the medical officer said that she had not carried out a physical examination during her assessment, that the practice of examining prisoners for signs of drug abuse had been discontinued, that she had recommended a communal cell because Mr D had mentioned a psychiatric problem in 1992, that there was no routine enquiry about a prisoner's contact with his or her GP and that Mr D's assessment had taken about five minutes.) The communal cell recommendation was entered in the reception register and on LIDS. PS later told the Commissioner's staff that Mr D's cell card had disappeared after his death and staff could not remember whether the communal cell recommendation had been entered on it. No recommendation was entered in the wing observation book and no special watch instructions were issued.

13. Mr D was located in a shared cell for the nights of 18/19 to 21/22 June. On 22 June the prisoner sharing the cell was discharged and another prisoner, whom I call Mr X, moved into Mr D's cell. According to Miss C, Mr X later told her (see paragraph 22) that he had been told by prison officers that Mr D was not to be alone in a cell because he had tried to commit suicide. Mr X also told Miss C that he had been present when Mr D had received a letter from his solicitor saying that bail had been refused and that Mr D had 'been devastated' by that news. (At the inquest a police officer said that he had been told by prison staff that Mr D had been refused bail.) Also on 22 June Miss C telephoned the prison probation officer (a different probation officer from the one that had visited Mr D on 22 March (paragraph 11)), who had known Mr D for several years, expressing concern about her brother. Miss C said that she had told him that she had found a noose hanging in her brother's flat and that the family were concerned about his state of mind. The probation officer later said that that telephone call had been made on behalf of Mrs B who was worried because Mr D had not been in contact with her. The probation officer agreed to talk to Mr D, which he did on the same day, and then telephoned Miss C to say that Mr D did not appear to be emotionally distressed. I have seen no record of Miss C's telephone call or of the probation officer's discussion with Mr D among the papers provided by PS.

14. On 25 June Mr X was discharged and Mr D was left alone in his cell. Prisoners returned to their cells at 2000 hours, pegging (paragraph 6) started and finished at 0545 hours the next morning. The officers on duty subsequently said that there had been no problems during that night, that Mr D had not operated his tally (paragraph 6), that they had not been aware of the communal cell recommendation and that no such instructions had been entered in the observation book. Mr D was found dead in his cell on the morning of 26 June.

15. On 27 June an allegation was made by a prisoner that Mr D had been bullied by another prisoner. The next day a report was made by a prison officer that prisoners had alleged that he (the prison officer) had been aware that Mr D intended to commit suicide. Also on 28 June the Coroner and the Governor of HMP Armley were formally notified of Mr D's death. The report to the Governor said that the communal cell recommendation for Mr D had been recorded in the reception register, on LIDS and on his cell card. The next day another prison official, in his report to the Governor, said that he had noted the communal cell recommendation on LIDS. He said that he had been advised that that could have been for a number of reasons and not necessarily because a prisoner was regarded as at risk of self-harm. He felt that that was an unsafe practice and suggested that, at minimum, all

recommendations for communal cell placements be noted in the wing observation book (paragraph 3). He said that where prisoners were regarded as at risk of self-harm a form F1997 must be completed.

16. The Coroner's Office were told by a prison governor (whom I call officer A) on 1 July 1993 that there was evidence to suggest that Mr D had been bullied by other prisoners (paragraph 15). On 6 July officer A completed his report of the internal inquiry held by HMP Armley into Mr D's death; he had examined Mr D's medical records, determined his movements within the prison and what pastoral care he had received and investigated the events surrounding his death. Officer A had also investigated reception, cell allocation and night patrol supervision procedures within the prison. In the course of the investigation he had interviewed prison staff but had not talked to any of the prisoners who had shared a cell with Mr D (one was still in prison but others had been discharged). Officer A had interviewed the prison officer whom prisoners had said had been aware of Mr D's intention to commit suicide (paragraph 15); the allegation had been denied by that officer. Officer A had also considered whether Mr D had been bullied by other prisoners and had notified the Coroner's Office that there was evidence to support that allegation. Officer A noted that the bullying appeared to have resulted from Mr D approaching other prisoners for cigarettes as he did not have access to cash and canteen privileges (paragraph 8). Although officer A said he found the reception procedure at HMP Armley to be 'archaic and dehumanising' he said that Mr D had shown no sign of suicidal tendencies or depression on arrival at HMP Armley; his investigation had not revealed why Mr D's communal cell instruction had not been followed up correctly. Officer A said that there might have been a case of neglect by staff in not ensuring that continuity of a communal cell placement was maintained or that Mr D might have 'slipped through the safety net'. He made a number of recommendations to improve procedures for the reception of prisoners, to introduce 'safety net' procedures for those prisoners for whom a communal cell placement had been recommended but no form F1997 completed, and to review other prison procedures.

17. On 13 July the then Member of Parliament wrote to the Governor at HMP Armley for confirmation that a full inquiry would be conducted into the death of Mr D and that the report of the inquiry would be sent to him. The Governor replied on 15 July saying that the internal inquiry and the report were confidential to PS but that he would make evidence available to the Coroner. On 23 July the then Member recommended to Miss C that she wait to see what information emerged at the inquest which was eventually held on 29 November. I have seen a copy of the transcript of the proceedings and note that evidence was taken from Mr D's GP, the prison's medical officer, prison and police officials and the probation officer who had visited Mr D on 22 March 1993 (paragraph 11). The verdict of the jury at the inquest was that Mr D had killed himself.

18. On 2 December the solicitor who had instructed Counsel appearing for the Treasury Solicitor and the Home Office at the inquest prepared his report on proceedings. He commented that he was surprised that little emphasis had been placed on the failure of HMP Armley to make sure that the communal cell recommendation made by the medical officer had been carried out and that the Coroner had not drawn attention to the evidence that Mr D had been bullied.

19. **1994** On 9 February 1994 the then Member asked the Home Secretary, through a Parliamentary Question, that a copy of the report of the prison inquiry

into Mr D's death be made public. That request was refused by the Director General of PS who said that it was not PS's practice to publish such reports as disclosure might undermine their effectiveness. He said they could release Mr D's prison medical records. On 15 February Miss C requested a copy of those records and asked whether Mr X, or the occupants of the cells adjacent to Mr D's cell, had been asked for information as part of the inquiry, why the recommendation that her brother be placed in a communal cell had not been entered in the wing observation book, and why a medical examination was not undertaken when Mr D was admitted to HMP Armley. PS replied on 21 February enclosing Mr D's records and saying they were looking into the questions she had raised; they offered a meeting to discuss the family's concerns. On 22 February the then Member asked the Home Secretary, again by a Parliamentary Question, how the publication of inquiry reports would undermine their effectiveness. The Director General replied on the same day saying they had reviewed the policy on disclosure of information to a deceased prisoner's family and decided that documents made available to the Coroner might be given, on request, to the next of kin in advance of an inquest. They would not, however, publish reports of internal investigations or make them available to the Coroner for two reasons.

> 'First, given the closed and potentially volatile nature of the prison environment publishing reports into prison incidents could cause problems for the day to day management of the prison. Knowledge within the prison of their contents and conclusions could, for example, lead to reprisals or disruption in the working relationships between staff. Second, the prospect of publication could discourage witnesses from cooperating with the inquiry and from being totally candid in the information they give to it. If they knew their identities were to be revealed, they might be at risk of being treated as informers. This could make it more difficult for the Prison Service to discover the truth...'.

20. On 25 February the then Member, in a further Parliamentary Question, asked the Home Secretary if he would, at the request of Members, deposit copies of reports of internal investigations into suicides in prisons in the Library of the House of Commons. The Home Secretary declined to do so as internal investigations were reviews which PS carried out for their own management purposes.

21. On 26 April Miss C, other family members and their solicitor, met PS representatives. I have seen a note prepared by the PS after that meeting in which they regarded the discussion as having met the family's concerns. However Miss C subsequently told Members of Parliament who pursued the case and later the Commissioner's staff that Mr D's family had been far from satisfied with PS's answers to their questions. On 3 May and 8 June Miss C's then Member of Parliament wrote to the Director General of PS asking that a copy of the internal inquiry report be made available. The Director General replied on 13 June along the same lines as his letter of 9 February to the first Member (paragraph 19).

22. On 24 June a governor at HMP Armley wrote to Mr X to say that Mr D's family wished to contact him concerning Mr D's death. He sent a copy of the text of the letter to Miss C; she noted on that copy that PS had taken a year to write to Mr X despite her repeated requests. (The Director General later told the Commissioner that HMP Armley had no record of those requests.) Mr X contacted Miss C and they met on 27 June. According to a record of that discussion, which was not signed by Mr X, he said that he had found aspects of Mr D's behaviour

disturbing. He said he had not told prison officers about Mr D's behaviour as they had first told him that Mr D should not be in a cell on his own; that was why he (Mr X) had been moved from his cell to share with Mr D. Mr X had not known that Mr D had died before the governor had written to him. (It has not been possible to interview Mr X during the course of the investigation.).

23. On 14 November the Member who referred the complaint to the Commissioner's predecessor wrote to the Home Secretary saying that he felt it would be beneficial to Mr D's family and PS if the results of the inquiry into Mr D's death were made public. On 24 November the Minister of State at the Home Office, in reply to a Parliamentary Question from the Member again asking that reports of internal inquiries into deaths in custody be made available, said he would discuss the matter with the Director General of PS. The Member referred Miss C's complaint to the Commissioner's predecessor on 25 November 1994. Miss C considered that the inquest verdict was flawed as evidence had not been sought from Mr X about Mr D's behaviour while they had shared a cell and, had that evidence been heard, the jury would have reached a different decision (paragraph 17).

24. **1995** The Director General, in his comments to the former Commissioner on the complaint, accepted that Mr D should not have been left alone in his cell on the night of 25/26 June 1993 and said that since Mr D's death new procedures had been introduced throughout PS for the care and support of those regarded as at risk of suicide or self-harm. Those instructions remind staff that, where a prisoner is placed in shared accommodation because he or she is regarded as at risk, a procedure must be in place to ensure that the prisoner is not left alone following the transfer of a cellmate. The Director General also said that the report of the internal inquiry into Mr D's death had not been made public as those that had given information had done so on the understanding that it would remain confidential. On 3 May the Minister of State replied to the Member's letter of 14 November 1994 (paragraph 23) apologising for the delay and saying that PS had re-examined their policy and recommended that, in future, reports of internal investigations into self-inflicted deaths in custody would be made available to the Coroner. On 31 May Miss C wrote to the Member commenting on the letter from the Home Secretary. She said it was unfair that copies of reports were to be sent to the Coroner but not to the deceased's family and that the meeting in April 1994 (paragraph 21) had not provided answers to the questions raised by Mr D's family.

25. On 26 October I asked the Permanent Secretary of the Home Office whether PS's policy of refusing to release reports of internal enquiries had been reviewed after the introduction of the Code (paragraph 10) and how, in general terms, the Home Office and PS would respond to a complaint made under the Code that a request for information contained in an internal inquiry report had been unreasonably withheld. In reply on 19 December the Permanent Secretary said that he understood PS's policy was not to release reports of internal inquiries on the grounds that they were internal documents and because their disclosure could prejudice security in prisons. He said that requests would be considered on an individual basis and that PS would need to consider whether the nature of the report justified it being withheld under the Code.

Findings

26. Since the original requests for disclosure of the internal inquiry report to Mr D's family, there have been significant developments in PS's general policy on making available information relevant to and contained in such reports.

Specifically, documents made available to the Coroner may now be given to the next of kin on request (paragraph 19) and it appeared from the Minister's letter of 3 May 1995 that internal inquiry reports themselves are now (paragraph 24) made available to the Coroner. In the light of those initiatives, it was not clear to me why the Permanent Secretary should argue, as he did during my investigation (paragraph 25), that internal inquiry reports might be exempt from disclosure under the Code in response to individual requests. That did not seem to me to be consistent with the decisions to make available information in the circumstances I have described and I put that point to the Permanent Secretary and to the Director General. In reply they said that internal inquiry reports were made available to the Coroner for reference, not as evidence and did not form part of those documents which were automatically disclosed. The Director General said that with hindsight it was apparent that PS had not made explicit in Ministerial correspondence the caveats which surrounded the disclosure of internal inquiry reports and that he understood how the advice contained in the correspondence of 22 February 1994 (paragraph 19) and 3 May 1995 appeared inconsistent. Whatever the Home Office and PS now say about how they should have advised the then Minister between November 1994 and May 1995, the Minister's letter of 3 May to the Member did not contain any of the restrictions which the Home Office and PS maintain were intended. I cannot be confident that that interpretation provides a reliable basis for replying to requests to disclose information from internal inquiry reports in the future even though the present Director General has said that PS are to review their investigation procedures, including the possible disclosure of inquiry reports. That matter does not affect the report into Mrs B's specific complaint and I shall continue to pursue my concerns with the Home Office and PS as a separate matter.

27. I have considered whether PS have acted reasonably in continuing to withhold from Miss C or Mrs B a copy of their internal inquiry report into Mr D's death. I concluded that there is little to justify such a continued refusal especially as PS have already made the majority of the information contained in the report known to Miss C or to the Coroner or in evidence at the inquest into Mr D's death. While the Code contains no assurance that pre-existing documents, as opposed to information, will be made available I saw no reason why those parts of the reports which concern information already known should not be made available. Where information contained in the report is not in the public domain but can be provided in such a way that it does not endanger individuals or prison security then there would seem no reason why that should not also be disclosed. I therefore asked the Director General whether PS would now disclose the report sought by Miss C and her family. He said that PS's review (paragraph 26) required considerable thought and extensive consultation both within PS and with other departments and agencies, that he felt it would be unwise to prejudge the outcome of that review and that he remained unable to agree to disclose the report to Mrs B. I am disappointed with the Director General's decision and hope that he will keep Mrs B's request under review. However I have seen a copy of PS's inquiry report and I can say that it contains no information which has not been disclosed in this report or given in evidence at the inquest into Mr D's death. Mrs B has therefore the information she sought, albeit not a copy of the inquiry report, and I consider that that has met, in spirit at least, the requirements of the Code.

28. My investigation revealed a catalogue of errors and omissions by prison staff when dealing with Mr D. At the time of his admission to HMP Armley in 18 June 1993, the medical officer's recommendation that Mr D be placed in a communal

cell had been entered in the reception register and on LIDS. Mr D had been placed in a communal cell from arrival in HMP Armley until the night of 25/26 June and at least some officers must have been aware of the communal cell recommendation. However that recommendation does not appear to have been known to staff on Mr D's wing. No entry was made in the wing observation book but that entry would have been dependant on an entry having been made on the prisoner's cell card (paragraph 5). Since Mr D's cell card has been unaccountably lost, I have not been able to confirm without doubt whether the communal cell recommendation had been recorded on it. I cannot say whether Mr D's tragic death would have been avoided had he not been alone in his cell on the night of 25 June but what is clear is that the medical officer had recommended that Mr D be placed in a communal cell and that had not happened. That merits my strongest criticism.

29. PS instructions recommend that staff in contact with prisoners on reception into prison should be alert to signs that a prisoner might be at risk of suicide or self-harm. A prison officer noted the scars on Mr D's wrists (paragraph 12) but, as the medical officer later said at the inquest, no medical examination was carried out. It is unfortunate that the reception assessment at HMP Armley was not more thorough; the most cursory of examinations would have revealed signs that Mr D had made a recent suicide attempt. At least three of the main risk factors were present in Mr D's case – previous suicide attempt, a history of depression and drug abuse. Miss C has said that she telephoned the prison probation officer after finding evidence in Mr D's flat that suggested he intended to harm himself but that officer has said that he had not understood there to be concerns that Mr D would attempt to harm himself. There seems to me to have been at least *prima facie* evidence that Mr D was at risk but lack of communication between prison staff and a failure to follow procedures resulted in that risk being unrecognised. Those shortcomings merit my strongest criticism. Although the Director General agreed that three main risk factors were present he said that a large proportion of those entering prison might have those symptoms and that they would not, in themselves, have automatically resulted in the raising of a form F1997. He said that identifying those at risk of self-injury required sensitive judgments which had to be made on the basis of a range of factors and without the benefit of hindsight. I welcome PS's new procedures (paragraph 24) which should go some way to ensure that those who should be in a communal cell are appropriately and safely accommodated. However, I remain concerned about the arrangements for the medical assessment of prisoners arriving at HMP Armley. The short time allowed for those assessments cannot fulfil PS's own recommendation that all prisoners receive a thorough health check (paragraph 3). I asked the Director General what steps he intended to take to improve arrangements. In reply he said PS had recognised for some years that the local facilities at HMP Armley for medical examination and admission procedures were inadequate; seven million pounds of capital funding had been provided to build an upgraded gate lodge, visits and reception area and that that work would start in 1997/98. In addition, prisoners arriving at HMP Armley are now examined by full-time prison doctors who are better placed to prescribe appropriate facilities within the prison and to follow through their recommendations. The Director General also said that in August 1994 new standards governing the assessment of prisoners' physical and mental health needs on their first reception into prison had been issued. All prisons had been given up to three years to ensure that local policy and practice reflected that standard and PS's Director of Health Care would be arranging for the implementation of all health care standards at local level to be properly audited and reviewed.

30. I turn now to officer A's investigation (paragraph 16) of Mr D's death. It seems to me that he made insufficient effort to determine the point at which the procedure for ensuring a consistent approach to the recommendation that Mr D be located in a communal cell had broken down. Having failed to identify the source of the procedural breakdown, he could not then recommend a remedy which would prevent a recurrence. However, I welcome officer A's recommendations that arose from the inquiry and I have seen evidence that those have been either implemented or actively considered within HMP Armley.

31. Although I do not doubt the sincerity of Miss C or any other member of her family, I cannot accept without doubt the information provided to Miss C by Mr X (paragraphs 13 and 22). During my investigation I have also found significant differences in the accounts of telephone conversations between Miss C and Mrs B and the probation officers who had had contact with Mr D (paragraphs 11 and 13) and in the absence of any independent corroborating evidence I cannot now determine what was said on those occasions. Similarly, I cannot comment on PS's apparent delay in meeting Miss C's requests to contact Mr X as HMP Armley have no record of them (paragraph 22). That calls into question the standard of record keeping at HMP Armley and I put it to the Director General that greater care needs to be taken by all prison officials in recording contact with a prisoner's family. Without at least a record of such contact the potential for confusion and conflict between prisoners, a prisoner's family and prison staff will be high. In reply the Director General said that, in order to minimise such confusion as occurred in Mr D's case, the Governor of HMP Armley had decided that families will be notified of a point of contact who will be responsible for providing information and responding to their queries. There also seemed, from the evidence given at the inquest, to be some confusion about the arrangements for probation officers to visit prisoners (paragraph 11) in HMP Armley. Visits by probation officers should not be unnecessarily delayed by the prison and I asked the Director General to review current procedures and publicity on that matter. In reply he said that in 1993, as now, visits by probation officers were not normally booked more than a week in advance because the movement of prisoners transferring elsewhere, being released on bail or being released by the courts led to an excessive number of cancellations. Most visits were booked two to four days in advance but, if a probation officer mentioned any concern about a prisoner, that information would be passed promptly to a senior prison officer, or to the duty governor, to arrange an early visit and to enable wing or health care staff to talk to the prisoner that day about his situation. The Director General added that field probation officers with such concerns would normally talk direct to the probation officers working within the prison.

Conclusion

32. The Director General apologised for the shortcomings on the part of PS and outlined the procedural improvements which had, or were taking place, throughout PS. The Director General continued to refuse to disclose a copy of the internal inquiry report saying that that policy was under review and that he could not prejudge the outcome. However I have seen a copy of PS's inquiry report and I can say that it contains no information which has not been disclosed either in this report or given in evidence at the inquest into Mr D's death. Mrs B has therefore the information she seeks. I regard that, together with the Director General's apologies and procedural improvements, to be a satisfactory outcome to a justified complaint.

C.993/97 – Mishandling by the Prison Service of the relocation of a prisoner under restraint

Summary of case

In November 1995 a prisoner died of positional asphyxia following restraint; his family complained to the Ombudsman about his treatment by prison staff. The Ombudsman found that his death had followed an incident which should have been treated as a problem requiring medical advice but was treated as a routine disciplinary problem, and that the procedures which had come with that approach had been applied with insufficient appreciation of the danger they posed. Those failings had been largely attributable to operational shortcomings on the part of PS in the form of, respectively, inadequate local arrangements to ensure that incidents involving prisoners in the prison's health care centre were managed by health care staff, and inadequate local and national arrangements for training regarding the risk of positional asphyxia following restraint. The Ombudsman concluded that it must remain a matter for speculation whether the prisoner's death would have occurred in the absence of those failings. He noted that since the death much work had been done by PS both locally and nationally to improve matters, but more remained to be done.

Full report

1. Ms Coles, acting on behalf of the family of the late Mr Kenneth Severin, complained about the way in which the Prison Service (PS) had treated Mr Severin, who died while on remand at HM Prison Belmarsh – in particular, that there had been a lack of communication between health care and non-health care staff about management of Mr Severin, a failure to follow guidelines concerning his relocation to an unfurnished cell, and a failure to ensure that officers were properly trained in the safe use of control and restraint techniques. She further complained that the report of an internal PS enquiry into Mr Severin's death had not been made available to his family before the inquest.

2. My investigation began in January 1998 once I had obtained comments from the Director General of PS after the referral of the complaint by the Member. I have not put into this report every detail investigated by my staff; but I am satisfied that no matter of significance has been overlooked. The question of whether Mr Severin should have been remanded to prison is outside my jurisdiction, as is any question as to the merits of the Government's policy for the location of mentally ill offenders. The question as to where in the prison Mr Severin should have been located was a matter for the clinical judgment of the doctors who examined him; the exercise of such clinical judgment is not something I am empowered to investigate. While the papers submitted by Ms Coles mentioned two subsequent deaths (by hanging) in the health care centre at HM Prison Belmarsh, and referred also to deaths in other prisons following the use of control and restraint techniques, none of those other deaths have been the subject of a complaint to me by the families concerned. My investigation concerns only PS's administrative actions in the case of Mr Severin.

Background

3. PS Standing Order 3E dated December 1990 deals with the management of violent prisoners, including the use of force, special accommodation, and mechanical restraints. It says that no officer shall use force unless absolutely necessary; if the use of force is necessary, no more force shall be used than is absolutely necessary to achieve the required objective; and so far as practicable only approved control and restraint techniques should be employed. An unfurnished cell

may be used for the temporary confinement of a violent prisoner if it is necessary to prevent the prisoner causing self-injury, injuring another prisoner or staff, damaging property, or creating a serious disturbance. Special accommodation should not be used as punishment. A prisoner may not normally be placed in such accommodation except on the prior authority of the Governor in charge; in urgent situations when the Governor cannot be contacted the decision may be taken by the most senior officer available, not lower than a principal or senior officer. Exceptionally, ratchet handcuffs may be used temporarily if it is necessary to move a prisoner following a violent outburst. A prisoner in special accommodation may be deprived of normal clothes if in the circumstances of the case that is considered essential to prevent self-injury or injury to others. A doctor should examine any prisoner who has been injured during efforts of staff to control him.

4. PS Standing Order 13 dated April 1991 deals with the health care of prisoners. Under the heading 'Special Medical Accommodation and Restraints' it says that except in an emergency a prisoner will be placed in an unfurnished room in the health care centre only on the instruction of a doctor. Exceptionally, the nurse in charge may authorise such action, taking urgent steps to seek endorsement by a doctor.

5. PS's Control and Restraint Training Manual describes, for the use of control and restraint instructors, the approved techniques taught to prison officers working in control and restraint teams to resolve incidents involving violent prisoners. PS's policy is that deployment in three-officer teams should be restricted to staff who in the previous twelve months have received initial or refresher training in the techniques.

6. In August 1992 PS issued to all prison Governors supplementary guidance to be inserted in the Manual, dealing particularly with measures to prevent the possible consequences of holding an inmate on the floor. The guidance said that all staff trained in the use of control and restraint techniques should be aware of the probability that acute respiratory distress (known as positional asphyxia) could be caused to a prisoner if he was subjected to prolonged restraint techniques involving direct pressure on the limbs, which could be transmitted to the chest. The probability increased in circumstances where the prisoner was held on the floor face downwards. Although it was not possible or realistic to lay down precise time limits, advice by the Directorate of Health Care suggested that the maximum period of such restraint should be five minutes. After that, ratchet handcuffs should be applied and the restraint holds relaxed. In order to maximise the prisoner's ability to breathe and communicate, the head should be turned to one side. No bodyweight should be applied to the prisoner's head, neck, chest or abdomen. Constant dialogue should be maintained with the prisoner to assess the level of distress being experienced; and if undue physical or respiratory distress was apparent the level of restraint should be reduced and medical assistance summoned. Wherever possible, a doctor or nurse should attend when a prisoner needed to be restrained. The letter to Governors which accompanied the supplementary guidance said that it should be brought to the attention of all staff trained in the use of control and restraint techniques as quickly as possible.

7. The edition of the Manual copyrighted on 1 January 1993 and currently in use contains the following instruction in the section dealing with prisoners who are placed face down on the floor:-

> 'Safety instructions
> The number one [member of the team] will ensure that the prisoner's ability to breathe is maintained. The number one will maintain constant dialogue with the prisoner throughout the process of restraint in order to detect any signs of distress and initiate appropriate action.'

8. Under paragraph 3(v) of Part I of the Code of Practice on Access to Government Information which came into force on 1 April 1994, bodies within my jurisdiction are obliged to release, in response to specific requests, information relating to their policies, actions, and decisions and other matters relating to their areas of responsibility, unless that information is exempt from disclosure under one or more of the exemptions in Part II of the Code.

Events in the case

9. On 1 November 1995 Mr Severin was admitted on remand to HM Prison Belmarsh. He was suffering from paranoid schizophrenia, but appeared to be stable on medication. He was located initially on the upper floor of the prison's health care centre, which contained accommodation for prisoners needing acute nursing care. On 10 November, following a reassessment by a doctor, he was relocated to the lower floor of the health care centre, which contained accommodation for prisoners needing assessment, observation, and low level nursing care. (The middle floor of the health care centre's three floors was used only for administrative purposes.) On 13 November Mr Severin was moved from a ward location to an individual cell. On 18 November he was charged with disobeying an order. On 21 November he was charged with being abusive toward prison staff.

10. Mr Severin died on the night of 25-26 November 1995. On that night the principal night orderly officer with responsibility for the entire prison was an officer whom I call officer A. He was supported by two other key-carrying orderly officers. The health care centre was in the charge of a senior nurse, who was also responsible for health care matters in the prison as a whole, under the guidance of on-call doctors, but responsible to the principal night orderly officer in non-health care matters. A nurse was responsible for supervising the upper floor of the health care centre with the help of two non-health care officers. The lower floor of the health care centre was supervised by a non-health care officer whom I call officer B. Subsequent accounts of events that night differ as to the precise timing of events and in certain other details. The following composite account has been drawn from statements by participants and witnesses appended to a report dated 26 November 1995 of an investigation into the death by a Governor at Belmarsh, statements given in November and December 1995 for the purposes of an investigation by the Metropolitan Police Service, evidence given to a coroner's inquest in January 1997, statements appended to a report dated February 1997 of a disciplinary enquiry by PS, and interviews by my staff with some of the officers involved. Because of its reliance upon individuals' recollections it must be regarded as indicative rather than definitive.

11. It appears that at about 8.45 pm on 25 November a non-health care officer on duty on the upper floor of the health care centre telephoned officer A to report that a line (a method used by prisoners for passing articles between cells) had been passed down from a cell on the upper floor to Mr Severin's cell. Officer A went with the two other orderly officers and a dog handler (customarily called to attend as a security precaution when cells were opened at night) to the cell on the upper floor and removed the line. The non-health care officer from the upper floor went with officer B to Mr Severin's cell and asked Mr Severin what had been passed to him,

but was unable to get a response. Mr Severin was rolling a large cigarette. (According to a statement made to the police by the prisoner who had passed the line to Mr Severin, he had sent him tobacco and rolling paper but had forgotten to include matches.) Mr Severin subsequently became vociferous, trying to get a light for his cigarette from officer B, the prisoner who had passed the line to him, and other prisoners, and saying that he should not be in prison and needed to get out. At some time after 10.00 pm but before midnight the nurse from the upper floor relieved officer B for a meal break. She spoke to Mr Severin, and at his request took him some cakes and sugar. On officer B's return the nurse returned to the upper floor. Mr Severin became increasingly noisy and agitated, shouting to other prisoners and repeatedly banging his cell furniture. Following contact between officer B, officer A, and the senior nurse, the senior nurse asked the nurse to attend to the situation. The nurse found Mr Severin standing in the middle of his cell wearing a coat and demanding to be released. She tried to talk to him and calm him down, but he continued shouting and became abusive and threatened to smash up the cell if he was not let out. The nurse told officer B that there was no more she could do for Mr Severin. She returned to the upper floor and told the senior nurse what had happened. A short while later officer B reported to officer A that Mr Severin was threatening to smash up his cell. Officer A went to Mr Severin's cell with the two other orderly officers and the dog handler. Officer A instructed that a cell be got ready on the upper floor of the health care centre. The senior nurse told the nurse to check if a 'strip cell' was ready; the nurse confirmed that one was available.

12. According to officer A, he went to Mr Severin's cell at approximately 1.00 am. According to another of the orderly officers, they arrived at the cell at approximately 12.45 am. In his statement to the police, officer B said that he had summoned officer A at 12.50 am, and the officers had arrived shortly afterwards. The relevant entries by officer B in the health care centre's chronological log state that he informed officer A of Mr Severin's continued disruptive behaviour at midnight, and that the officers arrived at approximately 12.30 am. My staff asked officer B about those entries. He said that he had probably made both entries at the same time after the entire incident had finished; his timings were guesswork because so much had been going on that he could not be accurate. The nurse and senior nurse when interviewed by my staff were unable to remember the precise times involved. The senior nurse estimated that he had made his request to the nurse to attend to Mr Severin at about 11.00 or 11.30 pm; at least half an hour after the nurse's return, at some time after midnight, he had been asked to get a cell ready in case Mr Severin had to be moved to the upper floor.

13. Officer A tried to talk to Mr Severin, who was wearing an outdoor jacket and shouting to be allowed to go home. Officer A told Mr Severin that if he did not calm down he would be relocated to the upper floor. Mr Severin replied that he wanted to go there. Officer A and the other two orderly officers entered the cell to escort Mr Severin upstairs. However, on being prevented from taking with him a portable cassette player he became aggressive, and was taken to the floor. A violent struggle ensued. Officer A and the orderly officers, with the assistance of officer B and the dog handler, restrained Mr Severin and placed him in ratchet handcuffs behind his back. They took him, still struggling under restraint, out of the cell. The senior nurse was alerted by the commotion, and sent a non-health care officer from the upper floor down to assist. A minute or so later the senior nurse went downstairs, arriving on the lower floor in time to see Mr Severin being forced into the lift. The senior nurse telephoned the nurse and told her to clear the corridor by the lift on the

upper floor. He then remained on the lower floor to provide cover there (officer B having accompanied Mr Severin and the other officers upstairs).

14. On arriving on the upper floor the officers were led by the nurse to the unfurnished cell. The nurse waited outside the cell. The officers placed Mr Severin on his front on a mattress. They began to remove his lower clothing. Mr Severin renewed his struggle. With the help of the other non-health care officer from the upper floor, the officers restrained him. They asked the nurse to fetch rubber gloves, on receipt of which they continued removal of Mr Severin's lower clothing. The nurse collected Mr Severin's clothing as it was thrown out of the cell. Suddenly, Mr Severin acquiesced. The officers completed removal of his lower clothing. Officer A removed the handcuffs, and Mr Severin's upper clothing was removed. On two occasions officer A asked the nurse to check Mr Severin. She saw that he was breathing, checked his head for cuts, and took his pulse; she found no cause for concern. (According to one officer's account, the nurse also checked Mr Severin's eyes.) Mr Severin remained lying passively on his front on the mattress with his arms behind his back as the officers left the cell and after the cell door had been closed. Officer A and the nurse became concerned by his immobility. The nurse went downstairs and asked the senior nurse to examine Mr Severin. The senior nurse did so and found that Mr Severin was not breathing and his pupils were non-reactive, although he still had a pulse. The senior nurse called for an ambulance and emergency resuscitation equipment. Attempts were made to resuscitate Mr Severin, and he was taken to hospital, where he arrived at 1.45 am. At 2.00 am he was pronounced dead.

15. The Governor's report of 26 November 1995 concluded, pending the results of a *post-mortem*, that circumstances pointed to Mr Severin having taken an illicit substance, whereupon he had become aggressive and violent and had then died. However, a toxicology report of 19 December 1995 did not find any drugs or alcohol that could have caused or contributed toward Mr Severin's death. A *post mortem* report of 17 January 1996 concluded that the most likely cause of death was asphyxia following restraint. In January 1996 the police sent a report of the results of their investigation to the Crown Prosecution Service. On 22 May the Crown Prosecution Service decided that criminal proceedings should not be instituted because there was insufficient evidence to provide a realistic prospect of conviction in respect of any criminal offence that might be alleged.

16. In December, as a result of a review, commissioned by the Director of Security and Programmes, of deaths in custody associated with physical or mechanical restraints, PS issued an Instruction to Governors on the use of control and restraint techniques by three-officer teams. It emphasised the continuing importance of the procedures set down in Standing Orders, the Training Manual, and previous Instructions to Governors, and the need for staff using the techniques to have received training within the previous 12 months. It said that a member of health care staff must attend every incident at which staff were deployed to restrain violent prisoners, including spontaneous episodes of violence, regardless of when they took place. It listed signs, such as exceptional strength or violence, which should lead staff to be particularly vigilant in monitoring the prisoner's responses, and be prepared to deal with him as a medical emergency if he suddenly became quiet. Health care staff should satisfy themselves that the prisoner was not physically distressed following relocation. Stripping in such cases should take place only if necessary and not as a routine procedure; the advice of health care

staff should be taken into account. Prisoners should not be left face down with their hands held behind their backs in mechanical restraints.

17. The Instruction to Governors was accompanied by a letter to all prison doctors asking them to ensure that health care staff were familiar with the contents of the Instruction. If control and restraint action was necessary in the main prison, a member of health care staff should attend on every occasion – in establishments without night nursing cover, that would require the attendance of the on-call doctor. If control and restraint action was necessary in the health care centre, a doctor should be present, unless it was judged that the prisoner's behaviour was a grave and immediate danger to himself and others, in which case the doctor should attend as soon as possible following the incident. The letter pointed out that a prisoner suffering from psychosis might when finally brought under control be so exhausted as to be unable to breathe unaided; careful attention should be paid to observing the respiratory rate and ensuring that chest movement was not impeded. Removal of clothing from restrained prisoners, which prolonged the period of restraint, was to be avoided. The letter concluded with a checklist of actions for health care staff in managing prisoners with medical problems under restraint, including the need to assess the level of consciousness, check vital signs and consider, by reference to further guidance contained in annexes to the letter, whether there was a physical, mental, or drug-related cause or contributory factor requiring medical attention in place of, or to supplement, the restraint action.

18. In January 1997 a Coroner's inquest into the death of Mr Severin recorded an open verdict, with positional asphyxia following restraint as the cause of death. Officer A and others who had been involved in moving Mr Severin on 26 November 1995 told the inquest that at that time they had received no instruction about positional asphyxia or any danger in placing a prisoner face down on the floor with hands fastened behind the back. The physical education officer at Belmarsh said that he had not heard of positional asphyxia; when training staff in control and restraint techniques involving placing the prisoner face down on the floor the instruction was that no pressure should be put on the prisoner's back or neck. There were no instructions about danger in applying handcuffs behind the back or what to do if the prisoner became distressed. The Coroner made the following recommendations:-

- There was a need for simple concise guidelines with regard to the transferring of patients in the health care centre of Belmarsh Prison to unfurnished strip cells.

- It was essential that in all cases of removal of the patient to a strip cell the medical personnel in the hospital should assess the situation before permission was given. That should be a medical officer and even on the rare occasion of dire emergency a medical officer should be alerted at the same time.

- There was a need for an urgent review of modes of intercommunication between staff in the hospital unit so that all nurses were conversant with the diagnosis and treatment of each inmate; and that should be easily and readily available to all medical personnel prior to giving permission for removal to a strip cell.

- There was a great need for an improvement in communication between nursing staff notes and visiting doctors. All doctors should be made aware by the nursing staff on duty at the time of his visit as to any change in the condition of the patients present in the hospital unit.

- There was a need for further immediate research into so called 'positional asphyxia'.

- There was an urgent need for guidelines indicating the great dangers in the face down position of restraint, especially involving arms handcuffed behind the back.

- There was a need to review communication procedures by the psychiatric community units with agencies such as police or magistrates' courts where the latter were seeking urgent medical or psychiatric information.

19. In February 1997 the report of PS's disciplinary enquiry found that the decision by officer A to move Mr Severin to the upper floor of the health care centre had been acceptable, especially since Mr Severin had appeared initially to agree, thus offering what appeared to be a passive resolution to a developing problem. However, the supporting arrangements had been poor: no measures had been in place against the possibility that Mr Severin would become violent; there had been no consultation with health care staff about the move; the officers moving Mr Severin had had no knowledge of the kind of cell in which he would be located (officer A had said that he had understood that an unfurnished cell would be the usual practice, and had expected that and regarded it as appropriate in Mr Severin's case, but had assumed that the decision would have been made by the senior nurse on duty and would become clear when they reached the upper floor); the officers had received little briefing before entering Mr Severin's cell; and there had been no medical presence during the move. The decision to move a disruptive prisoner to an unfurnished cell should have been authorised beforehand by a senior nurse, who would normally have expected to secure authorisation from a doctor. There had been a lack of communication between non-health care officers and health care staff, largely due to officer B working direct to officer A, thus cutting out important medical information and background on Mr Severin. The head of health care at Belmarsh told the enquiry that in Mr Severin's case solutions other than removal might have been sought if a nurse had been available for consultation on the lower floor, but at that time the staffing arrangements in the health care centre had provided for only non-health care staff to be present on the lower floor at night. The report noted that the night orderly instruction manual in use at Belmarsh did not contain instructions for the use of special accommodation. None of the officers involved in moving Mr Severin had received refresher training in control and restraint techniques within the previous 12 months. At the time of the incident there had been no programme of refresher training in place, and the training department had not kept records of staff who had undertaken such training. Nevertheless, the conduct of the removal under restraint had been in line with standard practice; and the use of handcuffs had been correct in accordance with Standing Order 3E (paragraph 3). The decision to strip Mr Severin had been reasonable and taken on the advice of health care staff. (Officer A had said that his understanding of the usual practice at Belmarsh was that prisoners placed in the unfurnished cell in the health care centre were stripped, and that that was what he would have expected and advised in Mr Severin's case, but that the decision was at the discretion of

health care staff. He believed he had received assent from the nurse before removing Mr Severin's clothing.)

20. The report of the disciplinary enquiry concluded that there had been no culpable negligence on the part of officer A; although he had made some errors of judgment and inappropriate assumptions, those had not contributed directly to the death of Mr Severin. The other staff involved in restraining Mr Severin had done so properly and professionally. Health care staff should have been more actively involved at all stages. The report made the following recommendations:

- There should be an immediate assessment of the feasibility of all night duty work within the health care centre being undertaken solely by health care (rather than non-specialist discipline) staff.

- The local dog strategy should emphasise the need for dog handlers to maintain direct control over their dogs when in close proximity to inmates.

- There should be a re-issue and distribution of revised notices in respect of revised health care procedures, review of care planning documentation and the use and authority for use of the protected room and unfurnished cell.

- Consideration should be given to developing more pro-active ways of ensuring the full and timely circulation of all important and relevant medical information between all grades of medical staff.

- The night orderly instructions should be revised and updated to include instructions for unlocking during 'state A' and instructions for the use of special accommodation. ('State A' is the security state during which prisoners are kept locked in their cells, unless it is necessary to unlock them on an individual basis, and staff numbers are at their lowest, such as at night.)

- The prison should ensure that all staff received mandatory training on control and restraint basic techniques. The backlog should be cleared within twelve months and thereafter national requirements should be met and complied with in full.

- Nationally, control and restraint training should give some focus to the issues of positional asphyxia and excited delirium syndrome (an excitable state which can be caused by drug intoxication or psychiatric illness).

21. On 25 February 1997 the Governor of Belmarsh wrote to Mr Severin's relatives saying that as a result of the Coroner's recommendations various actions had been taken within Belmarsh. In particular, concise guidelines were available to all staff working in the health care centre regarding the use of unfurnished rooms for clinical reasons and staff were aware of the need to be conversant with them. The decision to place a prisoner in such a room was to be taken by a doctor or, in an emergency, a senior nurse followed by review by a doctor. PS were currently considering how national control and restraint training could give some focus to the issues of positional asphyxia and excited delirium syndrome; the Governor had given advice on those conditions to staff at Belmarsh at a meeting on 15 January 1997. Control and restraint refresher training was currently the primary training priority at Belmarsh. The full text of the Governor's letter is reproduced at appendix A.

Comments of the Director General of PS on the complaint

22. The Director General expressed his regret that health care staff had not been more actively involved in and consulted on the decision to move Mr Severin. Officer A's decision to authorise the move could be viewed as a reasonable one in the circumstances; however, making such a move without consultation with a doctor or nurse had not been consistent with agreed policy. There had been inadequate local written procedures to cover such a situation; that had since been rectified.

23. The Director General also expressed his regret that although the staff who had dealt with Mr Severin had been trained in control and restraint techniques none of them had received refresher training in the previous twelve months. It was difficult to say to what extent the absence of refresher training had contributed to the events surrounding the death. At that time the dangers associated with positional asphyxia had not been widely known. PS's disciplinary enquiry had found that staff had carried out control and restraint procedures in a professional manner, while dealing with an extraordinarily aggressive and uncontrollable individual.

24. The Director General concluded that Mr Severin's death had been deeply regrettable and particularly tragic. Since 1989 there had been seven deaths associated with the use of restraint procedures; in the majority of instances the procedures were used safely without injury to staff or prisoners. In February 1996 PS had completed a review of such deaths, in the light of which Instructions to Governors on the use of control and restraint techniques had been re-examined. In December 1996 further guidance had been issued (paragraph 16). There had been no such deaths in 1996 and 1997. PS were continuing to improve and refine procedures to reduce the likelihood of further tragedies of that kind.

25. Regarding disclosure to Mr Severin's family of PS's internal report of 26 November 1995, the Director General said that it was not PS policy to disclose reports of internal investigations conducted in confidence. They were not therefore made available to the legal representatives of families prior to inquests. Reports were, however, made available to the coroner. PS were currently re-examining their policy on disclosure of investigation reports, but had no plans to change it retrospectively.

Findings

26. At the root of PS's failure to manage the events of the night of 25-26 November 1995 as they should have done was the absence of health care staff from the lower floor of the Belmarsh health care centre during the night. It seems that, although a nurse had been involved in an earlier attempt to calm Mr Severin, his move to the upper floor was instigated and managed exclusively by non-health care staff. While the decisions made were in accordance with Standing Order 3E (paragraph 3), they took no account of Standing Order 13 (paragraph 4). I accept that Mr Severin was being disruptive, and that the disruption, and the possibility of its escalation, on the face of things justified the decision to move him. However, it seems that that decision brought with it assumptions that such a move would as a matter of routine be to an unfurnished cell where Mr Severin would be stripped. Perhaps crucially, Mr Severin was prevented from taking his cassette player with him, which changed what appears initially to have been a consensual move into a violent struggle. I recognise that officer A told the inquest that Mr Severin was threatening to smash up his cell and that it is possible to justify such action – as officer A testified – on the grounds of preventing Mr Severin from harming himself after being re-settled in accommodation on the upper floor. It seems that there was also a suspicion that Mr Severin's behaviour was the result of his having taken an illicit substance. It may be

that the staff involved lost sight of the fact that they were dealing with a sick person; in any event, whatever concerns they had for his safety, fully clothed and in furnished accommodation, needed to be balanced against the possibility of the harm which might be caused by a forced move and strip. Balancing such concerns demanded medical expertise and a knowledge of Mr Severin's medical history, which was why medical authorisation of the move, as required by Standing Order 13, was so important. If the on-call doctor had been consulted and medical attention brought to bear, other options might have been considered and an entirely different approach to the incident might have resulted. At the very least, if the senior nurse had been involved as he should have been in the initial handling of the incident, his knowledge of Mr Severin's condition would have armed him with a greater awareness than non-health care staff of the way in which Mr Severin might perceive events and be expected to react to them; that in turn might have made the officers more determined and more able to ensure that Mr Severin's co-operation was maintained throughout the episode and that the use of force was avoided. In the event, in the matter of his removal Mr Severin received no more care than would have been accorded to a healthy prisoner in the main prison, despite the fact that he was mentally ill and had accordingly been located in the health care centre. I conclude that a combination of inadequate health care staffing and inadequate communication between non-health care and health care staff denied Mr Severin medical consideration at the time when he most needed it, and allowed less well judged approaches to the situation to prevail. That merits my strongest criticism.

27. I asked the Director General what arrangements had since been put in place at Belmarsh to implement the recommendations of the report of the disciplinary enquiry (paragraph 20). The Director General replied as follows:-

- The lower floor of the health care centre has been closed as prisoner accommodation. All prisoners resident in the health care centre are located on the upper floor and night cover is provided by a mixture of discipline and health care staff (with the latter predominating).

- The local dog procedural document was revised immediately after the disciplinary enquiry to make it clear that handlers should remain in proper control of their dogs at all times.

- New guidelines on the use of unfurnished rooms for prisoners were issued in May 1998. These guidelines make it clear in what circumstances such accommodation can be used and on the authority for use.

- Regular staff briefings in the health care centre were put in place as outlined in the governor's letter of 25 February 1997 (appendix A).

- Revised night orderly officer instructions have been issued, setting out the arrangements for unlocking during state A. These were further revised and brought up to date in October 1998.

- 68% of staff have received the required annual refresher training in control and restraint basic techniques. This is an improvement of more than 100% on the situation at the time of the disciplinary investigation. The small percentage of staff still requiring to be trained is a product of the high staff turnover at Belmarsh.

28. The effect of the shortcomings described in paragraph 26 above might have been mitigated had the officers who moved Mr Severin been fully aware of the dangers associated with the control and restraint techniques which they applied. The guidance issued by PS in August 1992 (paragraph 6) went part of the way towards addressing the danger of positional asphyxia by limiting the period for which prisoners should be held face down on the floor by officers. That guidance was purportedly incorporated in PS's Training Manual in January 1993 in 'Safety instructions' (paragraph 7). An officer from the Security Group of PS Headquarters read those instructions to the inquest; the version to which he referred was dated 1 January 1993 and contained the sentence : 'Whenever an inmate is held face down on the floor the maximum period of continuous restraint should not exceed five minutes.' That additional sentence does not appear in the copy of the Manual which PS gave my staff in June 1998, which, although it too is dated 1 January 1993, reads as quoted in paragraph 7 above. PS have been unable to explain that discrepancy. In any event, the evidence given to the inquest by the Belmarsh physical education officer (paragraph 18) shows that in practice the only safety instruction passed on to officers at Belmarsh was that pressure to the prisoner's back or neck was to be avoided. Finally, PS's disciplinary enquiry (paragraph 19) found that the officers who dealt with Mr Severin had not received the regular refresher training in control and restraint techniques that PS's policy required.

29. It is clear that, one way or another, no more than an extremely curtailed rendition of the supplementary guidance of August 1992 actually became a lasting part of PS's training programme, and in the process the gist of the message was lost. Moreover, that guidance itself did not specifically identify the risk of positional asphyxia from restraining prisoners face down with their hands behind their backs, and left open the possibility that prisoners would be left handcuffed in that position. That point was not addressed until the Instruction to Governors of December 1996 (paragraphs 16 and 17). That Instruction has still not been incorporated in the Training Manual. I appreciate the difficulty of formulating instructions which take account of developing medical knowledge and are also workable in practice; but at the time of Mr Severin's death the problem was already several years old. In sum, PS were slow to alert prison Governors fully to the danger of positional asphyxia; they failed to translate such warnings as they gave into adequate instructions for their training staff; and the training arrangements at Belmarsh failed to keep officers up to date regarding such limited modifications as were made. The result was that in 1995 Mr Severin was dealt with in the same way as he would have been in 1990, despite the deaths which had occurred in the meantime. That was a deeply unsatisfactory state of affairs.

30. I asked the Director General what arrangements had since been put in place at Belmarsh to ensure full implementation of the Instruction to Governors of December 1996. I also asked what further steps had been taken or were proposed nationally to ensure that all training in control and restraint techniques fully incorporated the latest medical advice on the potential dangers, warning signs, and how to respond to them, and when the Training Manual would be revised to reflect that. The Director General replied that the requirements of the Instruction to Governors of December 1996 had been put in place at Belmarsh by way of a governor's order issued in January 1997. He described the following national measures:-

- Following the Coroner's inquiry into Mr Severin's death, additional guidance was issued to all prison officers outlining the signs and symptoms of medical distress that may result from the application of control and restraint techniques on a violent prisoner and the action to be taken thereafter.

- All 600 local control and restraint instructors have been further advised about the signs and symptoms of medical distress and told to include reference to the danger signals in all control and restraint refresher training. This is reinforced annually when instructors are required to be re-certificated.

- All officers who attend control and restraint advanced training (approximately 6,000 per year) receive specific instructions on monitoring prisoners' responses during the application of control and restraint techniques.

- PS Order 1600, which is due for publication later this year, will include further guidance on the signs and symptoms of medical distress.

- The control and restraint Manuals are currently being further revised following a fundamental review of all control and restraint techniques. They are due for publication in the new year.

31. If PS's guidance had been implemented effectively through instruction and training, officer A and his team should have been aware that their actions, if prolonged beyond five minutes, could cause Mr Severin acute respiratory distress; and Mr Severin should have been released from restraints after at most five minutes, whether fully stripped or not. I have been unable to establish the precise length of time for which Mr Severin was restrained. Participants and witnesses have given differing estimates of the times at which events occurred, the time they occupied and the intervals between them. There is an entry in the health care centre's incident log which states that Mr Severin was identified as a medical emergency at 1.05 am; however, the log entry for when the incident began appears to be unreliable (paragraph 12). Officer A told the disciplinary enquiry that, although he found it very hard to gauge, he estimated that the whole incident from the point the restraint had begun to the point he had left the unfurnished cell had taken about ten minutes. Officer B estimated that probably the initial contact between officer A's team and Mr Severin, their entering the cell, the ensuing struggle in the lower health care centre, and entering the lift had taken about ten minutes. The senior nurse estimated that a maximum of ten minutes had elapsed between the time he had heard Mr Severin being brought to the lift and the time he had entered the unfurnished cell to examine him. In the circumstances I must leave open the question of how long Mr Severin was kept under restraint; it follows that I can make no finding as to the extent, if any, to which effective implementation of PS's guidance would have made a difference to the way Mr Severin was treated.

32. There is also the possibility that the assurance provided by the presence of a nurse might have led the officers to proceed as they did even if their awareness of the danger had been higher. I note that the nurse checked Mr Severin on two occasions. However, when my staff asked the nurse about those checks, she said that the usual practice at that time would have been for a nurse to see a prisoner who had been restrained after the restraint had ended, to make sure that he had not been injured; it had not been usual to be asked to check a prisoner while he was still under restraint, and she had not understood why she was being asked to do so in

Mr Severin's case. She had thought that perhaps it was because he might have cut himself during the struggle. In the circumstances she had felt vulnerable to attack by Mr Severin. It seems that for those reasons the assurance provided by her presence was largely false. The instructions for health care staff in dealing with prisoners under restraint which PS issued in December 1996 should remedy that deficiency (paragraph 17). However, they rely upon the willingness and ability of health care staff to become closely engaged with a violent situation at an early stage. I asked the Director General of PS what action had been taken or was proposed to ensure that health care staff nationally would approach that task with confidence. The Director General replied as follows:-

> 'Heads of Health Care are responsible for the local implementation of health care instructions and guidance, and for identifying and meeting related local training needs. For the future, the Directorate of Health Care has been working with others in PS Headquarters on a review of control and restraint policy. The outcome of this work will be to introduce additional modifications to the techniques for control and restraint, designed to further reduce the potential risk to the health of prisoners under restraint, and to continue development of the national training programme to ensure that the training needs of all staff, including health care, are effectively met in this regard.'

33. To sum up, Mr Severin's death followed an incident which should have been treated by PS as a problem requiring medical advice, but was treated as a routine disciplinary problem; the procedures which came with that approach were applied with insufficient appreciation of the danger they posed. Those failings were largely attributable to operational shortcomings on the part of PS, in the form of, respectively, inadequate local arrangements to ensure that incidents involving prisoners in the health care centre were managed by health care staff, and inadequate local and national arrangements for training regarding the risk of positional asphyxia following restraint. Whether Mr Severin's death would have occurred in the absence of those failings must remain a matter for speculation.

34. I turn finally to the question of disclosure by PS of their internal report on Mr Severin's death to his family prior to the inquest. That is a matter which is still under discussion between my staff and PS. In order not to delay further the issue of this report, I have decided to make that aspect of the complaint the subject of a supplementary report, which I will issue separately to the Member as soon as possible.

Conclusion

35. Ms Coles's complaint on behalf of Mr Severin's family was fully justified. Since Mr Severin's death much work has been done by PS, at HM Prison Belmarsh and nationally, to improve matters; more remains to be done. I hope that my investigation and this report will have made a positive contribution to that process; I would regard that as a worthwhile outcome to the complaint.

THE GOVERNOR'S LETTER OF 25 FEBRUARY 1997

As a result of the Recommendations proposed by [the Coroner], the following actions have been taken within Belmarsh.

1. Concise guidelines are available to all staff working in the Health Care Centre, together with more comprehensive documents from which they are drawn, regarding the use of unfurnished rooms for clinical reasons. All staff are aware that they must be fully conversant in the protocol and it is line management's responsibility to ensure that they are.

2. The decision to place a patient in an unfurnished room must, except in an emergency, be taken personally by the Medical Officer (on duty doctor). The decision remains under continuous review and must be reversed at the earliest clinically appropriate time. In an emergency, however, the Senior Health Officer or nurse can authorise its use but must inform the Medical Officer and Duty Governor immediately. It is then the decision of the Medical Officer as to whether the use of the room is continued.

3. During any 24 hour period four handover sessions take place in order that staff are fully aware of each patient's condition. This is a mandatory requirement. This exchange of information is further supplemented by a daily clinical meeting between the Medical Officer and Senior Health Care Staff. At this meeting each patient is discussed in detail. As line managers, it is the responsibility of the Senior Health Care staff to pass this information on to their staff.

4. Nursing notes are used to record the patient's condition and any changes that may occur. These provide a comprehensive picture of the well being of each patient located in the Health Care Centre and are made available, together with the Inmate Medical Record, to any visiting doctor.

At Greenwich Magistrates' Court there is a liaison psychiatric team from the Bracton Centre of Bexley Hospital in attendance most days of the week. This liaison psychiatric team is available to advise Magistrates on the mental state of the prisoners at the court. If a person who may be suffering from a psychiatric illness is remanded in custody, the liaison team pass on their findings to the Health Care staff at HMP Belmarsh.

In addition to the liaison psychiatric team, the Magistrates can request the preparation of a psychiatric report on an inmate remanded in custody to HMP Belmarsh. This report is prepared by a doctor who is an approved practitioner under Section 12 of the Mental Health Act of 1983. Paragraph 2 of this Section states that such a practitioner is approved by the Secretary of State as having special experience in the diagnosis or treatment of mental disorders. Two Medical Officers employed at HMP Belmarsh have Section 12 approval.

All prisoners entering HMP Belmarsh at Reception, undergo a very comprehensive examination of their physical and psychiatric state. A Health Care Worker, in the presence of a doctor, ask them specific questions about their psychiatric state and

their abuse of illegal substances. In this way prisoners who appear to be suffering from a psychiatric illness are admitted to the Hospital at HMP Belmarsh for further assessment and diagnosis.

Up until April 1996, a trainee Psychiatric Registrar was employed at HMP Belmarsh. Arrangements are soon to be introduced in which a Consultant Psychiatrist will visit the establishment each day during the working week.

All psychiatrically ill patients in the Hospital and on the Houseblocks at HMP Belmarsh are constantly reviewed by both nursing Health Care staff and Medical Officers. Where appropriate, mentally ill inmates are referred to NHS Hospital for admission under the relevant Section of the Mental Health Act. Regrettably, because of the lack of beds in the NHS, some mentally ill patients have to wait many months before a bed is made available. It should be pointed out, that unlike many psychiatric units in the NHS which depend on the backup of auxiliary nurses, the vast majority of Health Care staff at HMP Belmarsh are qualified nurses many of whom have special training and experience in mental health.

Prison Service Headquarters are currently considering how national control and restraint training can give some focus to the issues of positional asphyxia and excited delirium syndrome. Locally at Belmarsh I held a full staff meeting on 15 January 1997 where I provided advice to staff on both conditions. In addition a transcript of the information provided at this meeting was issued to each and every individual uniformed member of staff within Belmarsh. Control and restraint refresher training is currently the primary training priority at Belmarsh.

A.27/99 – Failure on the part of the Prison Service to release a report of an internal inquiry into a death in custody

Summary of case

The Ombudsman found fully justified the complaint by the family of Mr Kenneth Severin, who died while on remand in HM Prison Belmarsh, that the Prison Service had not made the internal investigation report available to them before the inquest into his death. In their response to the Ombudsman at the beginning of his investigation the Prison Service made no reference to the Code of Practice on Access to Government Information (the Code) until prompted by his staff. The Prison Service then cited Code Exemptions 2; 4(a), (b) and (c); 7(b); 8(a); 12 and 14 in support of their policy not to release internal investigation reports to anyone other than the Coroner. The Ombudsman found that none of the exemptions cited applied and invited the Prison Service to release the report to the Severin family. The Director-General of the Prison Service agreed to do so and said that the Prison Service would have a new policy in place by 1 April 1999 in relation to the release of such reports on deaths in custody after that date.

Full report

1. Ms Coles, acting on behalf of the family of the late Mr Kenneth Severin, complained about the way in which the Prison Service (PS) had treated Mr Severin, who died while on remand at HM Prison Belmarsh: in particular, that there had been a lack of communication between health care and non-health care staff about the management of Mr Severin; a failure to follow guidelines concerning his relocation to an unfurnished cell; and a failure to ensure that officers were properly trained in the safe use of control and restraint techniques. She further complained that the report of an internal PS enquiry into Mr Severin's death had not been made available to his family before the inquest.

2. I issued my report into the allegations of maladministration on the part of PS in November 1998 (under the reference C.993/97) while discussions with them were still continuing about their policy in relation to the release of PS documents in the light of the Code of Practice on Access to Government Information (the Code). This is my supplementary report on that aspect of my investigation.

Background

3. Mr Severin died on 26 November 1995. Following his death, the lawyer instructed to represent Mr Severin's family (the solicitor) asked for certain documents relating to Mr Severin's treatment and death at HM Prison Belmarsh. On 30 November 1995 he wrote to the Prison Governor (the Governor) saying:

> 'We note that Prison Service policy is that it would be prepared to disclose to the next of kin or their legal representative on request the relevant document *(sic)* which have been provided to the Coroner for the purpose of the Inquest. In this respect we enclose [Mr Severin's mother's] signed consent for disclosure.
>
> '...We would, therefore, be grateful if, in advance of the Inquest, you would disclose to us all the documentation which will be disclosed to the Coroner ...'.

This letter was copied to the Treasury Solicitor (T Sol). On 5 December 1995 the solicitor wrote to the Coroner, asking him to confirm that he had no objections to HMP Belmarsh disclosing any such documentation to his family as soon as possible.

4. On 8 January 1996 T Sol wrote to the solicitor enclosing the following documentation from Belmarsh: the out-patients log; the chronological log; the continuous medical record from 1 to 26 November 1995; and the nursing record. On 2 July the solicitor wrote to the Coroner to say that he had received documentation from HMP Belmarsh but no statements. On 17 December 1996 the solicitor wrote again to T Sol saying:

> '...we are aware that you have confirmed on 26th January 1996 that you have disclosed to us all documentation which has been disclosed to the Coroner. We would be grateful if you would confirm that the position remains the same. We note that to date we have still not received statements from prison officers attached to the hospital wing in connection with the circumstances of Kenneth Severin's death. We would have expected that *such statements would have been taken in connection with the prison's own internal inquiry* (my *italics*) and would be grateful for disclosure...
>
> 'We have previously had confirmation by both the police and the Coroner that they have no objection to disclosure in this case.
>
> We would be grateful for a response as a matter of urgency.'

The solicitor told my officer that he did not recall receiving a reply to this letter (and T Sol confirmed that no reply was sent). The inquest opened on 2 January 1997 at Southwark Crown Court. On the first day of the inquest Counsel for the Prison Officers' Association and the Royal College of Nursing agreed to disclose to all the interested parties the witness statements made by prison staff. However, these were not the same statements as those which formed an annex to the PS internal inquiry report. These were not released; nor was the report itself.

Reasons for refusing access

5. I know from a previous investigation that the PS's refusal to release their internal report was in accordance with their existing policy on disclosure. That earlier investigation revealed, in my view, sufficient inconsistencies in the PS's responses on the matter to lead my staff to question the basis of the policy. They renewed their questioning in the light of Mr Severin's case. In his response to the statement of complaint at the start of my investigation, the Director General of the PS confirmed that it was not PS policy to disclose reports of internal inquiries conducted in confidence. They were, therefore, not made available to the legal representatives of families before the inquest, although they were given on request to any Coroner who might wish to see them as part of the background. Information collated during the internal investigation report, which was produced by a governor at Belmarsh, was in any event brought out during the inquest into Mr Severin's death. Although PS were at present re-examining their policy on the disclosure of investigation reports, there were no plans to change it retrospectively.

6. In response to further inquiries made by my staff, the PS Director of Security said that the issue of the disclosure of internal investigation reports was highly complex and sensitive. They were made available to the Coroner purely for background purposes: they were not provided as evidence to be placed in the public domain. The reports were produced for several reasons, including internal ones. As such they were likely, in general terms, to be protected from disclosure under a wide range of exemptions. These included, potentially:

Exemption 2	(Internal discussion and advice)
Exemption 4	(Law enforcement and legal proceedings, in particular sub-sections (a), (b) and (c)
Exemption 7	(Effective management and operations of the public service, in particular sub-section (b)
Exemption 8	(Public employment, public appointments and honours, in particular sub-section (a)
Exemption 12	(Privacy of an individual)
Exemption 14	(Information given in confidence)

7. In relation to the release of the report into the death of Mr Severin, the Director of Security said that the PS investigation had been particularly limited in scope owing to the circumstances surrounding the death and the early police investigation following it. He said that disclosure of the internal report before the inquest would have run the risk of prejudicing subsequent legal or disciplinary proceedings, and claimed Exemptions 4 and 8 of the Code in support of this view. (This was the first time the PS had referred to either the Code or any of its exemptions in respect of this information request.)

8. The Director of Security confirmed that the PS were taking the Code into account in considering a revision of their policy on the treatment of internal investigation reports. He said that their overall aim was to reach a position where they could disclose as much information contained in a report as soon as possible, subject to not prejudicing the conduct of other proceedings or investigations, any criminal investigation or proceedings, and any disciplinary action. The PS aimed to have a protocol in place to facilitate this progress by April 1999.

Assessment

9. The issue I have to consider is the refusal to release to his family, before the inquest, the report of an internal PS investigation into the death of a remand prisoner, together with the associated witness statements. The PS lawyers (T Sol and Counsel) had a copy of the report and its attachments, and a copy of those documents was given to the Coroner as background information. All the prison officers whose statements, taken immediately after Mr Severin's death, provided the raw material from which the chronology of the night's events was constructed, were subsequently questioned by the Coroner and Counsel in open court, as were two former prisoners. I have examined the report. It consists, in the main, of a brief factual account of the events of the night of 25/26 November. There are various annexes attached to it, which consist of prison records, incident report forms and witness statements compiled on 26 November. I note also the Coroner's statement that the inquest was required to establish four matters: who the deceased was; when he died; where he died; and how he died.

10. In considering the applicability of the Code to the information sought by the complainant I have looked only at the two exemptions cited by the Director of Security (paragraph 7), as the PS have not suggested that any others apply in this particular case. I turn first to Exemption 4. The PS did not specify which sub-sections of Exemption 4 they thought applied to the information in question: I

assume they are relying on the three sub-sections they identified as applicable, in general terms, to the kind of information usually found in their internal inquiry reports: and indeed the other four sub-sections do not appear to be relevant. The three sub-sections read, in full:

(a) Information whose disclosure could prejudice the administration of justice (including fair trial), legal proceedings or the proceedings of any tribunal, public inquiry or other formal investigations (whether actual or likely) or whose disclosure is, has been, or is likely to be addressed in the context of such proceedings.

(b) Information whose disclosure could prejudice the enforcement or proper administration of the law, including the prevention, investigation or detection of crime, or the apprehension or prosecution of offenders.

(c) Information relating to legal proceedings or the proceedings of any tribunal, public inquiry or other formal investigation which have been completed or terminated, or relating to investigations which have or might have resulted in proceedings.

11. In considering the possible application of Exemption 4 I need to determine how disclosure of the information contained in the report and associated documents before the inquest might, in the PS's words, 'have run the risk of prejudicing subsequent legal....proceedings'. I must note at the outset that the PS have provided no evidence in support of this assertion: in other words, their argument depends essentially upon a view that the family *might* (my *italics*) have used the information in this way had they been given it before the inquest began, presumably by disseminating it in such a way that it could be said to have interfered with the course of justice. I have seen no evidence for such an assertion. I also need to ask – what proceedings? The purpose of the inquest was to establish, as the Coroner made clear, what had happened. The internal report and witness statements consisted primarily of factual accounts by those involved of what took place – statements which were subject to cross-examination at the inquest by lawyers representing all the parties. I find it difficult to accept an argument which, in effect, denies one of those parties an opportunity of access to part of the available evidence when the underlying purpose (to establish what happened) can be achieved only by ensuring that all those involved are on equal terms in testing the various witnesses whose evidence is presented. It seems to me that proceedings at the inquest could only have been assisted, not prejudiced, by providing the report to the family beforehand, particularly as it would then have allowed them a full exploration of any possible inconsistencies in the evidence.

12. If it is the case, as I believe, that disclosure of the report in advance could not have prejudiced the inquest, what other proceedings could it have prejudiced? In practical terms, the answer is 'none'. I have been given no evidence that criminal proceedings were in contemplation (although I accept that the police were considering the events); and no criminal proceedings followed. But even if they had followed, they could only have been against some or all of those members of the prison staff who had played a part in the circumstances which led to Mr Severin's death, and the evidence would have been provided in the main by the statements of those staff themselves. I cannot suppose that the PS is arguing that the report could have been withheld from any such proceedings, or indeed from any consideration

by the police or other relevant authority of whether or not such proceedings should take place. Allowing the family access to the information in the internal report, therefore, could not in this case have prejudiced any criminal investigation. In any event, the information relating to Mr Severin's death would have been considered in public in the Coroner's Court. If criminal proceedings had begun before the conclusion of the inquest then the inquest proceedings would, in all probability, have been adjourned. Moreover, in that event the media and others are subject to strict rules on what may be reported. Those rules would equally apply to criminal proceedings begun after the conclusion of the inquest. I therefore do not believe that allowing the family access to the information contained in the report could have harmed any legal proceedings had any in fact occurred. The test of prejudice has to be applied to each case on its merits: on this occasion, I do not find that Exemption 4 applies.

13. The other exemption claimed by the PS is Exemption 8, which is essentially concerned with matters related to public employment. It appears, from their general view about the exemptions which might be applied to reports of this kind (paragraph 6 above), that it is sub-section (a), which relates to personnel records, that the PS have in mind; again, the other sub-sections do not seem to be in point. In that context, the PS have said that the release of the report before the inquest might have harmed any subsequent disciplinary proceedings. To my mind, this argument has little or no force. To begin with, such matters are internal to the PS. The family, even if fully aware of all the facts surrounding the case, could have had no influence on either the conduct or the outcome of any proceedings. Nor would it have made any difference to those who might have been the subject of such proceedings, as they would themselves have been the main authors of any testimony used against them. In fact, there were no such proceedings. Additionally, I do not consider that the report and the information in it can be held to constitute a personnel record of the kind referred to in the exemption. In an earlier case (A.32/96, published in *Selected Cases Fourth Report 1997-98*) I concluded that a similar kind of report did not constitute a personnel record (although comments on the contents of such a report, when referring to individuals and placed on their personal files, undoubtedly would). On that basis, I find that Exemption 8 does not apply to the information sought.

Findings

14. I have seen the evidence which shows that a request was made to the PS before the inquest for the release of all the documentation made available to the Coroner. That documentation included the internal inquiry report and its associated witness statements. Some information was subsequently provided, but not the report and those other documents. The request, as far as it related to the report, appears not to have been explicitly rejected; but neither was it complied with. The later failure of either the PS or T Sol to respond to the solicitor's faxed request of December 1996 for confirmation that he had received all the documentation disclosed to the Coroner (paragraph 4) merits my criticism: in effect, the request for the internal report was ignored. I have seen no evidence to suggest that the complainant's request was considered even on its specific merits, let alone by reference to the Code. The Code was not referred to when the complainant originally sought the information, nor was it mentioned when the PS responded to the statement of complaint issued by my office. I find that failure hard to understand and impossible to justify. The Code has been in existence now since April 1994. The PS should have been generally aware of its requirements, particularly when responding to the

statement of complaint, since my Office had recently reported on a complaint (see paragraph 5) of a similar nature. They made no attempt to justify their decisions by reference to exemptions under the Code until prompted by my staff, some while after my statement of complaint had issued. Even then, their response referred to no fewer than six exemptions (a practice I and my predecessor have criticised in previous investigations) although it appeared that, in practice, they were applying only two of them to the case in question. Every request for information should be considered on its individual merits, a process which I do not believe was undergone here. I find that the PS have not been able to make a case that the information should have been withheld before the inquest. I believe that the information should have been provided at that time. As to the question of whether or not the information should be provided now to the family, I take the view that it should. The contents of the report did, of course, form the subject matter of the inquest, so it could be argued that the matter is now in the public domain. The family do not, however, know what the report actually contains because they have not seen it. Because I can find no reason under the Code to deny the family access to the information the report holds, it is my belief that it should be released to them, and I so recommend. I suggest that, in accordance with practice in other cases, this would best be done by provision of the document itself.

Conclusion

15. I welcome the PS's declared intention to develop a new policy on the treatment of internal investigation reports in line with the requirements of the Code, to be operational from 1 April 1999. However, the fact remains that each request for disclosure should, on an individual basis, be under consideration now in relation to the Code and its requirements. On that basis, I invited PS to release a copy of their internal inquiry report to Mr Severin's family.

16. In reply, the Director General of the Prison Service said that at the time of the request for the internal investigation report and accompanying statements these documents would not have been disclosed to anyone other than the Coroner before an inquest. That was because of an assumption, however wrong, that they would not be appropriate for disclosure beyond the Coroner. The Director General accepted that their policy should have been made clear and wished to apologise unreservedly to Mr Severin's family for the PS's failure to do so. He also accepted my criticisms that the PS did not apply the Code in this case or give any specific reasons for the exemptions they cited.

17. In conclusion, the Director General said he was satisfied that the needs of Mr Severin's family were such that they should have the reassurance that there was nothing in the internal report that had not already emerged at the inquest and agreed to release the report. He also offered to clarify any points with Mr Severin's family if they would find that helpful.

18. I regard this as a satisfactory outcome to a justified complaint.

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