Investigation into the circumstances surrounding the death of a man at HMP Featherstone in April 2008

Report by the Prisons and Probation Ombudsman for England and Wales

July 2010

This is the report of an investigation into the circumstances surrounding the death by hanging of a male prisoner at HMP Featherstone on Sunday 6 April 2008. He was the sole occupant of cell 29 in Houseblock 3 at the prison. He was last seen alive in his cell between 8.05pm and 8.30pm on the evening of 5 April.

I offer my sympathy and condolences to the man's wife and all family members. I apologise for the delay with my report, and any additional distress this may have caused. I am pleased to record the excellent liaison between the prison and the family and to learn that the man's wife believes that staff did all they could to keep her husband safe.

An Investigator from my office carried out the investigation on my behalf. As part of his investigation he asked for an independent review of the man's clinical management. I am grateful to the Clinical Governance Manager, who carried out the review on behalf of South Staffordshire NHS Primary Care Trust. I appreciate also the willing cooperation of the Governor and all staff at Featherstone, notably the Governor who acted as liaison officer.

The man was discovered hanging at about 5.35am on 6 April 2008 by a night patrol officer, who was conducting a scheduled roll check. (The ligature consisted of a shoelace, attached to his neck and the window bars of the cell.) Instead of entering the cell as he should have done, the Night Patrol Officer used his radio to call the communications centre for assistance, identifying the incident as 'Code Blue'. This is Featherstone terminology for a prisoner having breathing difficulties. Such a message does not require the Communications Officer to call an ambulance. Instead, he calls for the orderly officer to investigate and awaits further instructions.

Accordingly, the Communications Officer called the night shift manager, a senior officer, who, together with his assistant, went into the cell at 5.40am. They observed the presence of rigor mortis in the man's body and instructed the Communications Officer to call an ambulance. Their observation may be significant as subsequent events combined to cause significant delay in the man receiving skilled medical treatment. The Communications Officer panicked and did not know how to call an ambulance. He eventually remembered how to make the call, and did so at 6.00am. The ambulance crew went first to HMYOI Brinsford, which is adjacent to Featherstone, mistakenly thinking that the emergency was there. The gatekeeper at Brinsford redirected them. I have examined the ambulance log. It makes no mention of arriving by mistake at Brinsford. Furthermore, the log shows that the crew arrived at Featherstone at 6.22am and were delayed at the gate. When they entered the prison they waited some time for an escort to the man's cell. The log lacks some credibility in that it shows the crew waiting in the prison grounds at 6.48am and certifying the man's death one minute later at 6.49am. Featherstone gatekeeper is unable to say whether or not the crew were delayed. He says only that he was dealing with another incident at the time and it is possible the ambulance was kept waiting.

Notwithstanding these serious failures, I think it unlikely that the man's life could have been saved once he was discovered hanging. I also judge that those responsible for the man's care could not reasonably have predicted his death.

I aim to complete my reports into any death in custody with all good speed, but on this occasion I was delayed by protracted investigations by other parties in respect of the role of the prison's communications officer on the day the man died. In addition, West Midlands Ambulance Service initially refused to supply information, only doing so on HM Coroner's direction. (It did not reach my investigator until 2 December 2008.) My investigator requested further information relating to the identity of a paramedic who certified the man's death, but did not receive it. Until my office operates under statutory powers, I am unable to insist upon cooperation with my investigations. However, I will be sending a copy of this report to the Chief Executive of the West Midlands Ambulance Service for his consideration.

The inquest following the man's death was concluded before the South Staffordshire coroner in November 2009. The cause of his death was found to be hanging and the jury concluded that he had killed himself.

I make three recommendations regarding the prison's plan for dealing with a death in custody, the night orders and staff training. The Offender Safety, Rights and Responsibilities Group in the National Offender Management Service informed me last month that all three recommendations have been accepted.

I apologise for the delay in issuing this final report. After the Investigator's retirement the necessary work has been undertaken by one of my Assistant Ombudsmen.

Jane Webb
Acting Prisons and Probation Ombudsman **July 2010**

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SUMMARY

The man arrived at HMP Featherstone on 21 October 2007 following his conviction and sentence of three years imprisonment at a local Crown Court. During the four and a half months he was at the prison, he established himself as a quiet, friendly man, popular both with staff and with other prisoners amongst whom he had one or two close friends. He was generally thought to be fine, but from time to time he confided to both staff and his prisoner friends that he was worried about the confiscation of his assets. He also told them that he was seriously concerned about further charges for which he said he would receive a long sentence.

My report demonstrates that prison staff and prisoners were aware of the man's problems, but he appears to have given no indication to staff that he contemplated taking his life. There were, however, clues as to his state of mind in the weeks leading to his death. In telephone conversations with his wife, he said he was depressed and that he did not think he was going to be able to deal with the trouble he was in. He said that he did not think that he could get through another long sentence. In addition, one prisoner friend had seen him practising plaiting shoelaces. He had asked a second prisoner about how to tie nooses, and a third prisoner about hunger strikes and overdosing on drugs. These prisoners did not think that this indicated that he was planning to take his life and did not report the conversations to staff. However, a fourth prisoner told my investigator that he had reported to a senior officer that he thought the man would kill himself. There is no doubt that the prisoner discussed the man's state of mind with the senior officer. However the senior officer told my investigator that, although he and the prisoner agreed the man was going through a difficult time, the prisoner did not say that he feared for the man's life. I have weighed this information carefully and have concluded that it is unlikely that the prisoner told the officer that the man was in danger of taking his life. In my judgment, the prisoner, although well-meaning, put his thoughts together and made the connections after the man had died.

The day before the man's death (Saturday 5 April 2008), he spent time socialising with his friends and with his wing senior officer, who knew him well. The prison chaplain, who also knew him well, spoke to him. The man telephoned his wife twice during the day, saying he was looking forward to her visiting him on the Sunday. At lock-up, he exchanged pleasantries with his friends before going to his cell. Nobody thought he was anything other than his usual self.

On Sunday 6 April 2008 at about 5.35am, the Night Patrol Officer was on duty in Houseblock 3 at the prison. He was coming to the end of his night shift and conducting a roll check. When he looked through the observation panel in cell 29 he saw the man hanging by a ligature fashioned from shoelaces, attached to his neck and to the window bars. Although Featherstone's Night Operation Order 11 instructs night patrols to enter the cell in such circumstances, the Night Patrol Officer did not go into the cell. He raised the alarm by radio to the communications centre and called for the orderly officer to attend the scene, using a coded message 'Code Blue'. This message was intended

to notify the Communications Officer that the Night patrol officer had discovered a prisoner who had serious breathing difficulties.

A Communications Officer was on duty in the communications room at the prison and took the Night Patrol Officer's message. The Communications Officer told my investigator that he did not know the meaning of 'Code Blue'. He contacted the Orderly Officer. The Orderly Officer and an Officer reached the man's cell within five minutes and instructed the Night Patrol Officer to call an ambulance. Twenty minutes were then lost when by his own account, the Night Patrol Officer panicked. He could not dial an ambulance. Featherstone had recently changed the way staff were able to access external lines, requiring them to key in a personal number in order to gain access to the outside world. This process was unnecessary to contact the emergency services as there was a dedicated telephone in the communications centre solely for this process. The Night Patrol Officer said he did not know this. He had also forgotten his personal number so that he could not find a way to dial 999 through the conventional route. He eventually remembered his personal code and, at 6.00am, called an ambulance. The Night Patrol Officer told my investigator that he was inadequately trained to do his job. He said that his induction training, some 12 months earlier, had been interrupted and eventually curtailed by operational demands at the prison.

The upshot was that, by the time the Night Patrol Officer called the ambulance, 20 minutes had elapsed. There was a further delay when the ambulance crew, notwithstanding that their record of notification shows the emergency was at Featherstone, went first to HMYOI Brinsford, adjacent to Featherstone, mistakenly thinking the emergency was there. They were redirected and arrived at Featherstone at 6.22am, 42 minutes after the night manager raised the alarm through the prison's communication centre. Ambulance records do not mention that they initially went to the wrong prison. However, they say that when the ambulance crew arrived at Featherstone they were delayed as the gatekeeper could not open the gate. The ambulance log records that by 6.48am they had gained access to the prison but were waiting inside the concourse for a member of staff to escort them to the man's cell. Paramedics certified the man's death at 6.49am. It seems unlikely that they could have been in an open area waiting for an escort at 6.48am and yet able to certify the man's death one minute later at 6.49. My investigator checked with the prison gatekeeper who does not remember the delay but says there may have been one as he was dealing concurrently in the prison with another incident. West Midlands Ambulance Service acknowledged in a March 2009 letter that their crew had gone initially to the wrong prison.

The delay in calling an ambulance, and the ambulance's late arrival, were very serious failures and could have been critical. However, when the Orderly Officer and the Officer went into the cell at 5.40am they observed the presence of rigor mortis in the man's body. For that reason, it seems likely that he had been dead for some time.

Once in the cell, the Officer supported the man's weight and the Orderly Officer used his anti-ligature knife to cut the shoe lace. Despite noting that the man's body was cold and that rigor mortis was present, they applied cardio pulmonary resuscitation.

The Governor and other senior staff arrived at the prison subsequently. Having ensured that the contingency plan for a prisoner's death in custody had been activated, the Governor held a meeting of all those who had been involved to establish what had happened and see if immediate lessons could be learned. The Deputy Governor contacted the family liaison officer at a prison near the man's family home and asked him to visit the man's wife to break the sad news. Together with the local prison's chaplain, the family liaison officer visited the man's wife and ensured that she was able to contact Featherstone, visit the prison, and keep in touch by telephone.

The man who died was a popular figure, described as a 'gentleman'. Following his death, members of staff attended his funeral and the Governor later held a remembrance service at the prison.

It is highly probable that the man was beyond help when the Night Patrol Officer first saw him hanging. Nevertheless, Featherstone should put measures in place to ensure adequate training for communication officers. They should also prepare a contingency plan to ensure that staff know what to do when 'Code Blue' is called. Despite the obvious shortcomings that I have listed above, staff at Featherstone took good care of the man during his sentence. I do not believe that they could reasonably have known that he would die at his own hand.

The inquest following the man's death was concluded before the South Staffordshire coroner in November 2009. The cause of the man's death was found to be hanging and the jury concluded that he had killed himself.

THE INVESTIGATION

1. My investigation opened in April 2008 when the Investigator visited Featherstone. During three days at the prison he interviewed five prisoners, six members of staff, and the Chairman and one other member of the Independent Monitoring Board. He visited all parts of the prison, some of them on several occasions, and conducted informal discussions with many staff and prisoners including the Governor and Deputy Governor. He made one follow up visit in December 2008. Having regard to comments made in 2006 by HM Chief Inspector of Prisons that relationships at Featherstone, although improving, were not uniformly good, the Investigator was particularly interested in the day-to-day relationships and communication between staff and prisoners.

2. The man's wife gave my family liaison officer her views about the care her husband received and the high level of support she has had from the prison since his death. She has asked me to reflect this in my report. The man's wife said that he could not have been looked after any better. The staff treated him with the utmost respect. She believes he was extremely depressed at being away from her and his family, and said that if she was not able to help him no one was. She had been with him since she was 15 years old and described him as her soul mate who had the biggest heart. She could not fault a single member of staff. She had good relationships with prison staff after the man's death. The prison held a service for him, and offered to pay the funeral costs. She asked if I would reflect in my report that she has no grievances at all against the prison or staff, and does not blame them in any way for her husband's death. She instead blames the fact that he was sent to prison in the first place and believes the jury were too young and lacking in interest for such a complex court case.

3. The man's sisters contacted HM Coroner and were put in touch with my investigator. The Investigator explained the background to their brother's death and gave details of the way in which he would conduct his investigation on my behalf. They asked to be kept informed of progress, particularly when the date was set for the man's inquest. The Investigator contacted my family liaison officer who telephoned the man's sisters and asked them if they had any further questions or concerns which should be considered during the investigation. They asked if we could clarify whether the man was on a 'suicide watch' at any time. I address the risk of suicide and self harm in a later section of my report.

HMP FEATHERSTONE

4. HMP Featherstone opened in 1976 and is a secure training prison holding 687 prisoners. It is of modern construction and has good facilities for work, education and training. Prisoners live in single and double cells. In common with many prisons, Featherstone has a degree of overcrowding.

5. In her report of an inspection in 2006, HM Chief Inspector of Prisons noted Featherstone's progress towards achieving a good balance of care for prisoners and security. She said that relationships between prisoners and staff, which had not always been good, had improved. In the past, worried about increased drug use, the prison had concentrated over much on security. Under the leadership of the new Governor, the prison was getting the balance right.

6. The Chairman of the Independent Monitoring Board, a local doctor, told my investigator that the prison ran well. He said that staff were trustworthy and that relationships were good between them and prisoners. The Chairman said that the Governor took suicide and self-harm very seriously and that Assessment, Care in Custody and Teamwork (ACCT) procedures (the Prison Service's system for suicide and self-harm monitoring and support) were good.

7. The Chairman of the Independent Monitoring Board had spoken to a prisoner who said he had warned the Wing Senior Officer that the man was in danger of committing suicide. The Chairman did not know the Wing Senior Officer previously and, although he could not say whose version was correct, he reiterated his view of the trustworthiness of Featherstone staff.

8. Two other prisoners have died by hanging at Featherstone during the last six years, one in April 2002 and one in May 2007. An inquest into each death apportioned no blame to anyone at the prison.

EVENTS LEADING TO THE MAN'S DEATH

9. The man appeared settled at Featherstone. He liked the prison and got on well with staff and prisoners. He worked hard and, throughout the latter part of 2007 and early part of 2008, appeared to be taking his sentence in his stride. He was, however, passionately concerned about his family and how they would manage if he was sentenced to a further term of imprisonment. This concern developed progressively, and towards the end of his life he appeared to think of nothing else.

10. He was a private man, friendly but unlikely to share his deepest thoughts with either staff or prisoners. Telephone transcripts of conversations between him and his wife, however, reveal that from time to time he was worried about the impending court proceedings.

11. With hindsight, it can be seen that he gave clues as to the true depth of his despair. However, at the time the signals he sent to prisoners were seen as indications that he was worried, but not to the point of considering suicide.

Telephone calls between 27 March and 5 April 2008

12. Prisoners' telephone calls are recorded and stored. Their content is not routinely monitored by staff although a random sample is checked. Following the man's death, my investigator examined transcripts of all the calls he made between 24 March and 5 April. All the calls were to his wife and family at their home address. The transcripts (of 64 separate calls) show that the man's wife spoke of her wholehearted love and support for her husband but that he, although sometimes cheerful in his conversation, at times told her he was feeling low. Of particular importance was his comment, when referring to the possibility of a long sentence, 'I don't think I could do it' and 'I don't know how it's going to end up.' In telephone conversations between 27 and 29 March, he talked of being 'depressed', 'not all right' and being 'down'. He asked, 'Are we going to get through this? I don't think we will.' He also said, 'I don't think I could do it' (referring to a long prison sentence). He made 11 telephone calls to his wife between 1 and 5 April and, although they were of a nature similar to earlier ones, there was much talk of legal matters. On Saturday 5 April, the day before he died, he called his wife four times, the last call being at 4.52pm. In that short call they exchanged loving messages and he said he was looking forward to his wife's visit to the prison the following day.

13. Two accounts of the man's demeanour in the week before his death are of particular interest. According to a prisoner, he warned the Wing Senior Officer that the man had talked of suicide. Although he remembers the conversation, the Wing Senior Officer says that the prisoner did not mention the possibility that the man would take his own life. I go into some detail below in my

investigator's account of interviews with the prisoner, the Wing Senior Officer and others.

Information from staff

14. The Wing Senior Officer told my investigator that he knew the man well from the day he arrived at the prison. He was the House Orderly and was trusted to work around the offices. The Wing Senior Officer described the man in the following terms:

> '[a] lovely if sometimes private man. He enjoyed Staff Company and would spend ages talking. He was one of the very few people I trusted unreservedly. He was a gentleman and had an informal relationship with staff, based on mutual respect.'

The Wing Senior Officer told my investigator that he talked to the man every day that he was on duty. He was aware also that he showed photographs of his family to other staff.

15. The Wing Senior Officer knew of the further charges but said:

> 'He seemed to be dealing with them with the support of his family. I said, "What have you done?" He said that he could get a long sentence but didn't go into detail. I knew about the confiscation order – I didn't know how much money was involved. He said "a considerable amount". He didn't talk numbers. It was the same with the further criminal charges. I knew he had legal visits to see either a solicitor or police but I didn't have details. There was no reason I should. I knew he was in trouble and he said he was looking at a long sentence but he appeared to be a strong-minded man. He didn't have mood swings and he knew his own mind. I knew that the confiscation order and prospect of further charges put him under stress but he appeared to get on with his life.'

16. According to the Wing Senior Officer, the man drew strength from his family, who were his main concern in life. He was very family orientated and always looked forward to his visits. On one occasion his wife was unable to get to the prison, being held up in traffic for hours. She telephoned the Wing Senior Officer and he went outside the prison to where the man's son was waiting for his mother's arrival. The Wing Senior Officer took him into the prison to wait for his mother. He said, 'They were a really nice family'.

17. The Wing Senior Officer said that the day before the man died (i.e 5 April), another prisoner had told him that the man was 'a bit stressed'. The Wing Senior Officer said that the prisoner did not mention any fear of the man hurting himself. He told the prisoner that he knew about the man's problems and that they talked regularly.

18. Later the same day, the Wing Senior Officer and the man had a cup of tea together and then watched the Grand National. The Wing Senior Officer told my investigator, 'he seemed fine. I was not worried at all about him. It was just a normal Saturday.'

19. The Wing Senior Officer said that, following the discovery of the man's body the next day, the prisoner had told him that he himself should have realised that the man was going to kill himself as the day before he had given him a full jar of Branston Pickle. The Wing Senior Officer told the prisoner that this in itself did not mean that the man no longer wished to live, and that he should not read too much into it.

20. The Wing Senior Officer heard later that the man had been practising tying slip knots. He knew nothing of this at the time. Had he known, he said that he would have found it unusual and worrying and would have asked the man what he was doing and why. With the benefit of hindsight, it was possible that this was some sort of dress-rehearsal for what happened afterwards.

21. Following the man's death, his wife visited Houseblock 3 with members of her family and the Wing Senior Officer spent some time with them. He took her to the man's cell. He had cleaned it during the morning so that it was fresh for her to see. She was understandably very upset but grateful to the prison for the care and friendship everybody had showed to the man and to her family.

22. The Wing Senior Officer said he was convinced that, when the man went into his cell for the last time on Saturday evening, he had no thoughts of suicide. He had been all right all day. They had watched the racing together and had a good day. The Wing Senior Officer thought that during the evening the man probably watched Match of the Day in his cell, as he was a big football fan. The Wing Senior Officer said:

> 'He may then have started thinking about his life, his money disappearing and the prospect of a long sentence for further offences. At that point he may have decided that enough was enough and, even though his family was close, he couldn't go on living.'

23. The Roman Catholic Chaplain told my investigator that the man had gone to the chapel from the time he arrived at Featherstone. He attended twice a week on a Wednesday and Saturday. The Chaplain described the man as 'old school' and said that he took pride in remembering sections of the Latin Mass. He took part in all the chapel activities and often read in services. He was likeable and had a very keen sense of humour which he shared with the Chaplain:

> ‘He was respected and, being a bit older, was looked upon by other prisoners as a man of wisdom, something of a father figure. He was a gentleman in every sense of the word.’

The Chaplain knew that the man was due back in court. He was worried that he might have to move prisons at the end of his current sentence and before the determination of the new case. He did not want to move and the Chaplain told him that he could apply to stay at the prison and would probably have a good chance of success. He had told the Chaplain that he could not serve another prison sentence.

24. On Saturday 5 April, he had come to Mass but left the service before the sacraments were administered. This was unprecedented for the man, who was away for some time. The Chaplain was worried and went to look for him. The man told him that his stomach was bad but he would come back in for the Lord’s Prayer and Communion. He returned and stayed for the remainder of the service, chatting to other prisoners and visitors. The Chaplain said, ‘he seemed as normal as anything’.

25. The next morning, the Chaplain conducted a service in a local hospital and then received a telephone call at about 9.20am telling him the man had died. He went to the prison and said prayers. He said that it took him some time to come to terms with the man’s death. He met the man’s wife and her family when they visited the prison and later held a memorial service for prisoners. The Chaplain said that the man’s wife appreciated all that prison staff had done for her husband.

26. The man had not told the Chaplain that that he would hurt himself and he did not think that he would. The man loved his family and they loved him. The Chaplain thought that the man was not someone who would take his own life, and was saddened and shocked when he heard that he was dead.

Information from prisoners

27. The prisoner who mentioned his concerns told my investigator that he knew the man as ‘Scouse’. He was a ‘mate’ who discussed his life before and in prison, but without talking about his family. The prisoner said that he noticed a change in the man on the Tuesday or Wednesday, four or five days before he died. He said, ‘Scouse had a sudden mood change. He seemed upset and down and seemed aimless,’ so he had offered to talk to him. The man who is the subject of this report had visited his cell and told him that he faced further charges. The prisoner said that the man had told him he would kill himself if he got a long sentence, and talked of a hunger strike or drug overdose but not hanging. The prisoner told the man not to consider killing himself and he thought that the man took notice of what he said:

> ‘I felt that he kept trying to get strength from me by asking me how I’d coped all this time and got through the days and years. It got to the point that he was leaving my cell, then he’d come back and I thought, oh no, not again.’

The prisoner did not report this conversation to any prison staff. The two men talked again on Saturday 5 April. The prisoner said in interview:

> ‘I noticed that something was not right. Alarm bells started ringing in my mind. I recalled his earlier comments in the week about suicide. He would say, “I don’t know how you cope” and then he would wander off somewhere else and then come back and ask me about radios or something random, for example, people he’d met. Then he’d go away again and come back. He wasn’t right.’

28. The prisoner said that he approached the Wing Senior Officer on 5 April:

> ‘I asked for a private word. We went to the lifer room. This is where the stories are going to clash. On my mother’s life and all my family’s who mean a lot to me this is what I remember happened next. I told the Wing Senior Officer, “I’m very concerned about the man.” He said, “Don’t worry about that, we know all about it. He’s got a lot on his plate at the moment but we’re keeping our eye on the situation.” I thought to myself, they don’t realise how serious this is. I’d had all day with his thinking patterns becoming very distorted. I said, “Look, we’re talking about a guy who’s been asking about suicide during the week. Something’s not right.” I never at all said that he’d spoken to me today but I believed there was a direct link between the mid-week behaviour and his mood on Saturday.’

29. The man visited the prisoner’s cell again that day, at about 3.30pm and stayed for about five minutes. The prisoner said:

> ‘He seemed ok. That was the last time I saw my friend Scouse. I don’t think that he mentioned suicide at all on the Saturday. But I knew he wasn’t right. He was carrying a load that was too heavy. With hindsight I think he had given up and he was trying to decide whether or not to do it. I’m not sure that he wanted to die. He may have been looking for me to agree with him and help make the decision easier. He was weighing up the decision I think. I know he was talking to others and I was just part of the jigsaw. Much of the time he wandered around.’

30. Another prisoner told my investigator that he had known the man since he arrived at Featherstone and that they were good friends. Although not in the same houseblock at the prison, they were both from Liverpool and knew some of the same people, including having relatives in common. The Prisoner said

that he used to go to Houseblock 3 where the man lived and they would talk together. The man would pass on his copy of the *Liverpool Echo*. The prisoner said:

> 'The man was completely normal but changed when he came back from court. I went to see him and he asked if one could be force fed if on hunger strike. I asked him if he was going on hunger strike and he said he was thinking about it in order to get a transfer. I told him he was going about it the wrong way and that he should make an application. He was in a pretty depressive mood. We talked for a while but he didn't say anything to cause me urgent concern or worry. This was a week before he died.'

31. The third prisoner to speak to my investigator said that he had known the man since October 2007. They lived on the same landing. He said that, about two weeks before he died, the man had visited the prisoner's cell and asked him to show him how to tie a ratchet knot. He said he had been watching a television programme on how to sheet lorries and he knew that the prisoner had previously done that sort of work. The prisoner showed the man but he could not tie the knot and gave up after about 45 minutes. He then asked the prisoner how to tie a simple slip knot. The prisoner showed him, and he returned on two or three occasions until he finally learnt how to do it. The prisoner said, 'The man didn't seem down. I never suspected that he wanted it for anything bad. I said later to a couple of people, hindsight's a bloody wonderful thing.'

32. Another prisoner told my investigator that he had known the man for about three months on Houseblock 3. They got on well. The prisoner described the man as a straightforward sort of person until he went to court when he changed and became very depressed. The prisoner said:

> 'I asked him what was wrong. He said he was facing serious charges and that he couldn't do another sentence. That was about a week before he died. On the day before he died, I saw him a few times during the day. At the end of the day, just before 5.30pm lock-up, we met as we were getting hot water to take to our cells. I said, "See you tomorrow," and he said, "Yes, see you tomorrow". I was surprised when officers told me the following day that he appeared to have taken his own life, even though I knew that he had been depressed since his return from court.'

33. Another p risoner said that he met the man in October 2007 when he was newly sentenced and they shared a cell in Houseblock 5. He said that after a month he was given a single cell in Houseblock 3. He let the man know where he was so that he could follow in due course, which happened shortly afterwards and they became close friends. He said that at least once a day they would spend time together and he learned all about the man's home circumstances. When the man telephoned home, the prisoner would often speak to his wife and

reassure her that the man was alright. They also exchanged greetings in the visiting room when she visited the man.

34. The same prisoner also said that the man changed in February or March 2008 after he went to court and began to speak of further charges. The day before he died, the prisoner went to see him. He told my investigator:

> 'The man had taken to lying on his bed for long periods. He said, "There's no way out." I asked him what he meant. He was just playing with a shoelace, plaiting it. I urged him not to do anything to hurt himself. He said, "Don't be daft, I've got my family. They're what I care about." '

The prisoner said that he would never have suspected that the man would do anything to himself. He had his family and they thought the world of him and supported him. The prisoner used to tell the man that he should be feeling sorry for him as he had no family, nowhere to live, and was about to be deported. "He'd laugh at that and agree with me." The prisoner said that the evening before the man died, the prisoners were locked in their cells at about 5.30pm. He saw the man getting hot water and called, "Safe?" [Is everything all right?] and he called back, "Yes." He asked the prisoner if he had any sweets and the prisoner gave him a Mars Bar. He learned next morning that the man had died.

35. The prisoner said that staff sent a Listener (a prisoner trained by the Samaritans to speak in confidence to other prisoners) to see him, but he did not need to talk to him as he felt alright. He said that it was easy to talk to staff and the Wing Senior Officer was particularly concerned for him. The Wing Senior Officer had said to him, 'I've seen people like you before. It's hard when you lose a good mate.'

36. Following the man's death, his wife and daughter, together with his wife's brother, came to Houseblock 3 where the prisoner met them. They said he should not blame himself. The man's wife told him that she had not thought that her husband would take his life and she understood that the prisoner had not expected it either. She said that she did not blame the prison either and said that 'it's nobody's fault'. After the man's funeral, his wife sent photographs to the prisoner.

37. My investigator met other staff and prisoners. All told a similar story that he was a good friend who became depressed during the early months of 2008.

The evening of 5 April

38. Prisoners were locked in their cells at about 5.30pm. At about 8.00pm, the Night Patrol Officer took over the night duty. He had worked as a night patrol at Featherstone for ten years. His duties were to check that all prisoners were safe in their cells at the beginning and end of his shift, make regular patrols of

the area, respond to any cell alarm bells, register his attendance at given points by operating an electronic recognition device, and ensure the general safety of Houseblock 3.

39. There were no prisoners who needed special watch for either health or security reasons, and there were no prisoners about whom staff had particular concerns. Unless there are special reasons, prisoners are not routinely monitored during the night hours. In the absence of special risk, unless they call for help by using an alarm bell within their cells, they remain unobserved until the next morning.

40. The Night Patrol Officer told my investigator that between 8.05pm and 8.30pm he made a physical check on all the prisoners. He opened the observation panel of each cell and ensured that the men were alright. Some were already in bed, others sitting in chairs, and some watching television. He said that all were in customary positions in their cells. The Night Patrol Officer did not know the man and could not recall where he was in the cell. Had he not been in the cell or had he been in an unnatural position, the Night Patrol Officer was certain that he would have noticed immediately and brought his concern to the attention of the Night Orderly Officer. It is likely, then, that the man was alive and well at about 8.30pm on Saturday 5 April.

41. The Night Patrol Officer said that the night was unremarkable. He remembered answering one or two routine calls, but his tour of duty was uneventful until early the following morning.

The morning of 6 April

42. At about 5.30am, the Night Patrol Officer started his roll check in preparation for reporting to the communications centre on the state of Houseblock 3 and the number of prisoners. During the course of this check, at about 5.35am, he looked through the observation panel of cell 29 and saw the man slumped, apparently suspended from the window bars. He immediately called the communications centre by radio, using the coded signal 'Code Blue,' and asked for the Night Manager to attend Houseblock 3. The Night Patrol Officer then waited for assistance to arrive.

43. The Night Patrol Officer told my investigator that his orders were not to enter a cell alone and he stayed outside the cell. He had a cell key, sealed inside a pouch commonly referred to as a 'sealed packet', and so he could have entered the cell immediately. The Night Patrol Officer said that he did not know about Featherstone's Night Operational Order Number 11, published for night patrol officers. It reads:

> '*11. Death/Suspected Death in Custody. Local Security Strategy 2.087.*
> If a prisoner is found and there is a possibility of death, inform the communication room and tell the operator you are entering the cell.

Ensure you get a response from the communication room operator and that they are dispatching additional staff to the scene.

'Break the sealed packet and enter the cell (staff may do so alone) giving due care and attention to your own safety in the case of a double occupied cell.

'DO NOT automatically assume death – render first aid using other staff to assist. If a person is hanging, support the body and cut down. Try and preserve the ligature knot for evidence. Lie the person on a flat surface and commence first aid (cardiopulmonary resuscitation).'

44. It is worrying that the Night Patrol Officer did not know about this very important part of his duties.

45. The alarm raised by the Night Patrol Officer in using the 'Code Blue' message identified to the Communications Officer that there was an incident in which a prisoner had breathing difficulties. (This code is used in similar circumstances in many prisons within the estate.)

46. The Communications Officer alerted the Orderly Officer. The Orderly Officer and an Officer, also on night duty, joined the Night Patrol Officer at the man's cell at 5.40am. The Orderly Officer immediately called the Communications Officer by radio and asked for an ambulance to attend as a matter of urgency. The Officer broke the seal of the cell key packet and all three staff went into cell 29. The Officer held the man up and the Orderly Officer cut the string around his neck. The Orderly Officer and the Officer noted the presence of rigor mortis and they had difficulty moving and straightening the man. The Night Patrol Officer moved furniture so that they could lay him flat. The Orderly Officer and the Officer started cardiopulmonary resuscitation (CPR).

47. Although the officers were at the man's cell within five minutes of being called, it was not until they arrived that they asked for an ambulance. 'Code Blue' always means an emergency and it would be preferable if the Communications Officer had called an ambulance without waiting for someone of seniority to attend.

48. The night Communications Officer had joined the Prison Service four years earlier at HMP The Mount in Hertfordshire. He transferred to Featherstone after three years as it was much nearer his home. His duties as communications officer required him to maintain contact by radio and telephone throughout the night with all staff on duty in the prison, liaising also with the outside world, particularly the emergency services.

49. It appears that there were two incidents of a similar nature during the early morning. An Operational Support Grade recalled some gate malfunction but

was unsure if this was in relation to the ambulance called for the man. Given the ambulance log, I think it was but the lack of accurate record keeping is regrettable.

50. At about 5.30am on the morning of 6 April, the Communications Officer made a routine test call to all outstations on the prison's radio network to ensure that they were in good reception areas. The Communications Officer told my investigator that about 5.35am the night patrol on duty in Houseblock 3, the Night Patrol Officer, called him by radio. The Communications Officer's recollection of that radio message was that the Night Patrol Officer said, 'I have a regulation or code blue, get the orderly officer.' The Communications Officer said that he had not heard the expression 'Code Blue' before the day of the man's death and he had no idea what it meant. Although he had previously found a prisoner hanging when he worked at The Mount, there was no coded message system there and on that occasion he had just passed a simple message to say what he had found.

51. The Communications Officer said that he had been expecting a call to confirm the roll and so he was surprised by the nature of the Night Patrol Officer's message. However, he immediately called the Orderly Officer.

52. The Communications Officer said that at 5.40am, having arrived at the man's cell, the Orderly Officer contacted him by radio and said, 'Get an ambulance.' The Communications Officer said:

> 'Things happened fast. It's possible that on this occasion I couldn't put my numbers into the phone to make the telephone call. I have a 12-digit code and can't make a call unless I enter it. I couldn't get a clear line. I may have dialled a wrong digit. It kept re-routing me.'

53. My investigator told the Communications Officer that he had examined staff codes for telephone access and they appeared to be eight digits. He asked the Communications Officer whether his code was similar. The Communications Officer said that he did not have details of his code to hand but agreed that it could be eight digits.

54. My investigator examined the telephone system in the communications centre and tested the procedure for contacting the emergency services by telephone. The emergency 999 number can be called quickly in two different ways:

- By picking up the receiver and dialing 999.
- By pressing a button clearly marked 999 (a speed dial) on the telephone.

In either case it is not necessary to enter the user's personal eight digit access code.

55. The Communications Officer said that, prior to the introduction of personal telephone codes, he knew that he could dial the emergency services directly but thought that the new system made instant access impossible. He did not realise that he could still use the communication centre telephone to dial 999 or alternatively to use the 'speed dial'. He said that he did not know he could contact the emergency services so easily. He also explained that the routine morning roll checks were being reported at the time, so many people were contacting him and he had to tell them that he was dealing with an emergency. He told my investigator:

> 'I became quite frightened. I have never been so frightened in my life. I had previously been involved in a horrific accident in which I lost the use of my arm. This brought it back to me and may have caused me to panic.'

56. The Communications Officer eventually remembered his personal code and gained telephone access. He dialled 999 and asked for an ambulance. He was surprised when my investigator told him that, according to the prison and ambulance service records, 20 minutes had elapsed between the Orderly Officer's instruction to call an ambulance and his actually making the call. The Communications Officer said, 'It's possible, because of the panic. I was having difficulty. I might have panicked.'

57. My investigator asked the Communications Officer to describe his training. He said that on his first night at Featherstone he was supposed to be on induction training but a prisoner had overdosed on drugs. Consequently, he had to cover someone else's duties to enable the prison to deal with the emergency. His induction training should have lasted for a week. Although he was shown around the prison, he was fully operational from the third night onwards. He had visited the communications room, which he described as similar to that at The Mount. The room at Featherstone was busy on the day he visited so he could not do much training, but the telephones and radios were similar to those at The Mount - with one notable exception. The staff at The Mount did not have personal telephone code numbers, so dialling was simply a matter of picking up the telephone and using it.

58. My investigator also asked the Communications Officer if he could say why the ambulance attended Brinsford instead of Featherstone and whether, in his panic, he could have given an imprecise message. He was certain that he had passed the correct message:

> 'My procedure never varies. I always say, "Good morning, afternoon or evening. This is the control room at HMP Featherstone, the Communications Officer speaking." I then pass my message. This applies whenever I make a call for a taxi, to the duty governor at home or to anyone else. I've never varied from that from day one of my service.'

The Communications Officer was certain that, even in his state of panic, he would not have departed from his usual script.

59. The Communications Officer said that Brinsford telephoned him to ask if he had called an ambulance. He said that he had done so and they should re-direct it to Featherstone. The communications officer at Brinsford also told him what a 'Code Blue' meant. The Communications Officer said, 'That really frightened me. I was shaking for hours. It brought back all my accident. Horrible memories.'

60. Worryingly, the Communications Officer concluded by saying that he had only learnt how the emergency telephones worked during the interview with my investigator, despite it taking place some time after the emergency on the night that the man died. He said that Featherstone should arrange more training for Night Patrol staff.

61. My investigator looked at the contingency plans available to the communications officer at Featherstone. They are contained in three volumes and detail the action to be taken in any of 42 contingencies, including fire, escape and disturbance. There is no contingency plan to cover a 'Code Blue' call, and I recommend that the Governor's revision of the contingency plan covers the action to be taken in response to such an emergency.

62. My investigator examined the Communications Officer's training record. It has two entries:

- 4 September 2007 – OSG Radio Procedures
- 9 January 2008 – ACCT (self-harm and suicide awareness) Foundation.

The Communications Officer appears to have had no other training. Whilst one might expect an Operational Support Grade, with four years experience gained in two different prisons, to know how to use communications centre telephones and to remain calm in an emergency, the Communications Officer's account of his training is supported by the lack of detail in his training record.

West Midlands Ambulance Service (WMAS)

63. My investigator made many telephone calls and wrote several emails and letters to officers of WMAS to ask for information about the morning of 6 April from their records. He was interested particularly in their record of the time the emergency call was made from Featherstone, and also wanted to establish why the ambulance first went to HMP Brinsford. The investigator also needed to scrutinise the notes made by those treating the man and eventually certifying his death.

64. My investigator eventually contacted HM Coroner who instructed WMAS to supply the information. WMAS complied with the Coroner's order and sent the information on November 27. My investigator received it on 2 December, some eight months after the man's death.

65. My investigator examined the WMAS patient report form which records the details of the man's death, from the initial call-out to the time that the paramedics left the prison. The initial call is marked clearly as originating from Featherstone. I assume that, by mistake, the ambulance crew went first to Brinsford, which is just a few hundred yards from Featherstone and has to be passed en route. The ambulance crew lost a few minutes as a consequence. HM Coroner may wish to draw this matter to the attention of the Ambulance Service and recommend that all emergency response crews are aware of the proximity of the two prisons and can identify one from the other.

66. The ambulance crew eventually arrived at Featherstone at 6.22am and were escorted to the man's cell. They checked immediately for signs of life and found none. A paramedic on a WMAS Cardiac PRF form certified the man's death at 6.49am.

EVENTS FOLLOWING THE MAN'S DEATH

67. The Governor held a meeting, known as a 'hot debrief' meeting, at 7.45am on the morning that the man died. The purpose of such a meeting is to ensure that all the information available at this early stage is captured, to establish if all that was possible had been done, and to mark and learn lessons for the future. The Governor also informed the Coroner and police, together with all the others on the serious incident notification list. He wrote to prisoners and staff, explaining that the man had died and expressing his regret.

68. The Deputy Governor, who is also the prison's family liaison officer, asked colleagues at the prison near the man's family to visit and inform the man's wife of her husband's death. The family liaison officer at the prison near to the man's family together with the chaplain went to the family home and broke the sad news to her. They kept in touch with the man's family and with Featherstone. The Governor wrote a personal letter to the man's wife, who later visited Featherstone together with her brother and her daughter. They talked with staff and prisoners, and the man's wife spent some time in his cell. The family said that they were much encouraged by the messages, both written and verbal, from all those who had known him.

69. The Deputy Governor and Governor attended the man's funeral. The chaplain subsequently held a memorial service at the prison, attended by staff and prisoners.

ISSUES CONSIDERED

Clinical Care

70. A Clinical Governance Manager coordinated the Clinical Review of the man's treatment in Featherstone. Her report was produced following consideration by a panel of South Staffordshire Primary Care Trust clinicians.

71. The Clinical Governance Manager notes that the man had not in the past harmed himself. He had a history of hypertension but no other identified physical or mental health problems. The prison medical officer prescribed drugs for hypertension and the prescription was renewed weekly. The man kept his medication in his possession and his condition was well controlled by the treatment.

72. The man did not seek medical treatment to help him deal with the stress he felt, although he had good contact with the healthcare department and regularly took the medication prescribed for hypertension.

73. In reviewing the medical and other prison files, the review team say that there was nothing untoward within the man's medical history and that he had no other clinical needs. The team judge that his health was managed well within the prison, and that he received a level of care equal to what he could have expected had he been in the community.

74. The team make two recommendations which I draw to the attention of the healthcare manager. First, clinicians should ensure that all entries are timed, with the name printed and designation given. Second, as a suitably qualified paramedic can confirm death, this should be incorporated into the prison's contingency plans to ensure that there are no unnecessary delays verifying the death. (My investigator asked about the second recommendation and it appears that Featherstone, not content with the paramedic's finding, required their own doctor to attend and certify the man's death.)

Risk of suicide and self harm

75. My investigator considered all aspects of the man's life at Featherstone. On the face of it, he led a normal life in prison and had many friends amongst both staff and prisoners. The investigator judged that Featherstone treats prisoners decently and with respect. All the systems were in place to ensure that prisoners needing help know how to access it through the staff, the Independent Monitoring Board, prisoner 'Listeners', or by confidential contact with the Samaritans.

76. The man was in touch with his wife and children. They were a close family and wrote and telephoned regularly. The man's wife and other family members visited the man at Featherstone at every opportunity. They knew that he was worried about court matters but his wife, who spoke to him every day, tried hard to keep his spirits up. He never hinted to her that he was considering harming himself.

77. All that said, my investigator has identified that in fact the man was becoming increasingly anxious, and possibly depressed. Those who recognised that he was less and less like his usual self thought that his anxiety was natural, having regard to complicated legal matters. Nobody, apart from the prisoner who said he discussed his concerns with the Wing Senior Officer, said that they spoke to staff about the extent of the man's feelings. His other friends, whilst recognising that all was not right, kept their thoughts to themselves.

78. The man had an easy relationship, based on mutual respect, with many staff and prisoners. I have described in some detail two important interviews my investigator conducted (those with the Wing Senior Officer and the prisoner who spoke to him about his concerns). The man neither asked for, nor received special favours, but the Wing Senior Officer embraced the best traditions of the Prison Service by his thoughtful and decent approach to his work. He knew that the man was anxious about the future in respect of his money and further criminal charges. In spite of their level of communication, and sharing many of his thoughts with the Wing Senior Officer, the man gave no signal to him that he might have been contemplating taking his own life. The Wing Senior Officer was confident that the man was alright when he last saw him the evening before he took his life.

79. A prisoner, anxious for his friend, approached the Wing Senior Officer. Accounts of the conversation are similar in all respects except one. The prisoner said he told the Wing Senior Officer that the man had talked of suicide earlier in the week before he died. However, the Wing Senior Officer is adamant that the prisoner did not refer to suicide. I do not think that the prisoner has intentionally misrepresented their conversation, but on balance I do not think that he mentioned the possibility that the man would take his own life. The Wing Senior Officer was clear about the content of the conversation and had a vivid recollection of the events of the day in question.

80. Following sequestration of his assets and facing the prospect of more court appearances for alleged offences, I believe that the man became more and more depressed each day. He eventually withdrew into himself and changed from the mature friend he was to many, to the introverted, care-worn man who eventually died in his cell. Several prisoners noted the deterioration, but only one prisoner thought that the man would harm himself. The Wing Senior Officer, sensitive to both the man's troubles and the need to respect his privacy, did not intrude, allowing the man to share with him as much as he felt able.

Response to the emergency

81. My investigator considered important acts and omissions when the man was found hanging in his cell. He assessed whether the prison's 'Code Blue' alert process was appropriate to deal with an emergency of this nature. He also reviewed whether those charged with making decisions and taking action were competent. Finally, my investigator considered whether or not the delay calling the Ambulance Service and the ambulance initially going to the wrong prison and subsequent delay at the prison gate contributed to the man's death.

82. When the man was found hanging in his cell, accounts from those who tried to help him strongly indicate that they were already too late. However the Night Patrol Officer did not know that his orders required him to enter the cell alone and he waited for the night manager's arrival. The Communications Officer who received the 'Code Blue' alert seems not to have understood what it meant. The prison had no contingency plans to cover 'Code Blue'. The Communications Officer did not know how to telephone the emergency services, notwithstanding his experience of some years. And the Ambulance Service was unable to distinguish between Brinsford and Featherstone prisons. All in all, this represents a lamentable state of affairs.

83. Notwithstanding that his training at Featherstone was inadequate, I judge that the Communications Officer should have made himself aware of how to make an emergency telephone call. He was the lifeline to the outside world for his colleagues, and it is of serious concern that he appears to have been so ill-equipped to do his job.

84. As I have said, I do not believe that the delays caused by each of the failures I have outlined above had an impact on the man's death. They were, nevertheless, very serious errors and I make recommendations in respect of each.

I recommend that the Governor draws Night Operational Order 11 to the attention of staff and requires them to comply with it.

I recommend that the Governor rewrites the prison's contingency plans to ensure that when a member of staff makes a 'Code Blue' call, he or she:

- **identifies precisely the nature of the emergency**
- **asks the communications officer to call an ambulance without waiting for instruction from a senior member of staff**
- **states the action to be taken by staff in response**.

I recommend that the Governor reviews and, where necessary, arranges comprehensive training for communications officers.

After the man's death

85. The Governor and staff took all appropriate actions following the man's death. The family liaison officer at Featherstone linked with his counterpart at the prison near the man's family who visited the man's wife at her home and broke the news sensitively and with compassion. Liaison between the prisons was good, and the man's wife visited Featherstone where staff and prisoners received her courteously and with all consideration. The Governor held a memorial service at the prison and members of staff went to the man's funeral in the family's local area.

86. I commend the excellent liaison between staff at Featherstone and the prison near the man's family home. They put a considerable effort into ensuring that the man's family were supported during this most difficult time. The liaison officers and supporting staff of both prisons showed humanity and compassion at the time and afterwards. They also spent many hours of their personal time so that the man's wife could find her way through the bureaucracy which was inevitable in the aftermath of her husband's death.

CONCLUSIONS

87. The man gave no clue of his intention to harm himself to the staff during the day before he died. He had not attempted suicide previously and there was no indication that he would do so. He enjoyed a normal social afternoon, watching television and having a cup of tea with the Wing Senior Officer, with whom he had a close relationship. He spoke to his wife on the telephone and looked forward to her visit the next day. He also exchanged pleasantries with his friends, one of whom gave him sweets, when they were locked in their cells for the night.

88. It is possible therefore, that just a few hours before his death the man was not contemplating harming himself that night. Nobody can say what led him to tie the ligature around his neck. We know that he was anxious about facing further charges and a further lengthy sentence. It may be that appreciation of this left him feeling without hope.

89. Given the man's private approach to his problems, I do not think that staff could reasonably have predicted his death.

90. Nevertheless, while I do not think that staff at Featherstone could have prevented the death of the man, this investigation has revealed serious and elementary failures in procedures once he was discovered hanging.

RECOMMENDATIONS

1. The Governor should draw Night Operational Order 11 to the attention of staff and require them to comply with it.

   The National Offender Management Service accepted this recommendation and responded thus:

Notice to Staff 050/2009 "First on Scene – Opening of Cell doors" was issued on 18 March 2009. The Notice draws the attention of staff to Night Operational Order 11 and the Local Security Strategy, which state that where there appears to be danger to life, cells may be unlocked with one member of staff once the Control room has been alerted.

2. The Governor should rewrite the prison's contingency plans to ensure that when a member of staff makes a 'Code Blue' call, he or she:
   - identifies precisely the nature of the emergency
   - asks the Communications Officer to call an ambulance without waiting for instruction from a senior member of staff
   - States the action to be taken by staff in response.

   The National Offender Management Service accepted this recommendation and responded thus:

Governor's Operational Order 021/2009 "Codes Blue and Red" was issued on 5 June 2009. The Order provides detailed instructions to staff for their first response to codes blue and red. Relevant contingency plan to be updated.

3. The Governor should review and, where necessary, arrange comprehensive training for communications officers.

   The National Offender Management Service accepted this recommendation and responded thus:

Memo sent to Head of Security / Operations on 23 March 2009, asking for comprehensive training to be arranged for communications officers.