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

Report by the Prisons and Probation Ombudsman for England and Wales

January 2009

The man was 60 years old when he died on 14 April 2008 in his cell at HMP Parkhurst. He was found hanging. My investigator, Family Liaison Officer (FLO), and I offer our sincere condolences to his family and friends for their sad loss.

I wish to thank the Governor of Parkhurst and the Deputy Governor for making the necessary facilities and information available to my investigator. I also wish to thank the prison's Liaison Officer for his invaluable assistance.

My report shows that the man had been released from prison on 11 December 2007, but immediately rearrested. Following an appearance at court, he returned to prison custody the following day, having been charged with new offences. For the purpose of my report, I have concentrated on the period from 12 December 2007 onwards, although I do refer to the man's previous prison sentence and contact with mental health services.

In the course of the investigation, I asked for a clinical review to be carried out into the medical care and treatment the man received in custody. I am grateful for the clinical reviewer's assistance. Because the man had been in contact with the Mental Health and Learning Disabilities Services within the two years preceding his death, the Isle of Wight (IOW) Primary Care Trust (PCT) commissioned its own review of his medical care. On 23 July 2008, the Associate Director IOW PCT, chaired a 'Review of Unexpected Death and Serious Mental Health Untoward Critical Incident' meeting, at St Mary's Hospital, Newport, IOW. As well as reviewing the man's medical care, the attendees considered a number of questions which my investigator asked and those raised by the man's family. I am grateful to the panel for their assistance and for the Associate Director's report.

Since taking over responsibility in April 2004 for the investigation of all deaths in prison custody, there have been four deaths at HMP Parkhurst prior to that of the man, all from natural causes. I have identified no similarities between those investigations and this one. Sadly, there has since been a further death at Parkhurst (it appears to have been from natural causes but is still under investigation).

This report makes three recommendations for the Governor and one for the Isle of Wight Primary Care Trust, and identifies three areas of good practice. It also includes details of an action plan drawn up by the Associate Director following her review meeting.

I must apologise for the delay in issuing my report. This has been caused by the pressure of work on my office and a delay in obtaining the Associate Director's report.

Stephen Shaw CBE
Prisons and Probation Ombudsman **January 2009**

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SUMMARY

On 14 April 2008, at about 8.30am, the man left Alpha (A) wing in HMP Parkhurst for exercise in the fresh air along with other A wing prisoners. Whilst taking exercise, he spoke to one of the prison teachers whom he had known for some time. It appeared to the teacher to be a normal, albeit brief, conversation, and nothing suggested to her that the man was in any way distressed or at risk of harming himself. At the end of the exercise period, the man returned to his cell, A 2.25, and was locked up for the remainder of the morning. From what can be ascertained, this was probably the last time that the man was seen alive.

At about 11.25am, prison officers began unlocking prisoners in preparation for serving lunch. An officer unlocked the cell doors on the landing and left them ajar, but did not fully open them. After completing this task, he continued with his duties supervising prisoners collecting their lunch.

After completing the serving of meals, another officer who was supervising prisoners at the servery area realised that the man had not collected his meal, and so went to his cell to ask if he wanted lunch. When the officer looked into the cell, at about 11.55am, he saw the man hanging in what appeared to him to be a seated position. The officer immediately summoned urgent assistance by using his prison radio.

In response to the officer's request for assistance, the wing manager arrived at the cell along with another member of staff. Between them they cut the ligature away from the man's neck and laid him on the floor of the cell. Shortly afterwards, prison medical staff arrived and, after assessing the man's condition, they started cardio pulmonary resuscitation (CPR), continuing until emergency ambulance staff arrived a little later. Ambulance staff were the first to arrive at the cell, followed soon after by emergency paramedics. After carrying out their own checks, they confirmed that the man had died.

As part of the normal prison contingency plans for any death in custody, the man's next of kin address details were obtained from his prison record. The deputy Governor, arranged for the prison's two family liaison officers to travel that afternoon to the address to break the sad news. Unfortunately, when they arrived at about 2.30pm, the man's family were not home. They left a note asking them to contact the prison as soon as possible. A member of the man's family rang the prison within one hour and spoke to one of the family liaison officers. After telling the family member of the death, arrangements were made to meet the man's family the following day.

I am satisfied that the man gave no indication to anyone about what he was to do on 14 April. Had he done so, I am equally satisfied that the support mechanisms were there for him. However, my report expresses concern at the length of time it took to discover that the man had harmed himself.

THE INVESTIGATION PROCESS

1. When my office was notified on 14 April 2008 of the man's death, the investigation was allocated to one of my investigators. He contacted the deputy Governor and arranged to travel to Parkhurst the following day to meet her and her team for the purpose of opening the investigation.

2. On 15 April, my investigator arrived at the prison where he met the deputy Governor and others invited to the meeting. At that meeting was a member the local branch of the Prison Officers' Association, the Operations Manager on 14 April, the prison's Head of Operations, one of the prison's Family Liaison Officers, the chairman of the prison's Independent Monitoring Board (IMB), another member of the IMB, and the prison's Acting Head of Healthcare.

3. The deputy Governor gave my investigator an overview of what had occurred on 14 April. Her briefing helped identify a number of people whom my investigator would want to speak to at a later date. In addition, others attending the meeting gave background information about the man and the prison. The prison's family liaison officer told the meeting how he and the prison chaplain had been to see the man's family at their home.

4. At the opening meeting with my investigator, the IMB chairman, said the Board felt the prison was well managed and a safe environment. He told my investigator that the man had not asked to see any member of the Board whilst at Parkhurst.

5. After the meeting, my investigator went to the cell where the man had been found. Before entering the cell, which was still sealed, the Liaison Officer confirmed with the police officer dealing with the death that it was not being treated as suspicious. Once this was confirmed, the officer agreed that the seal could be removed to allow my investigator to enter. My investigator was shown inside the cell, which had been fitted out to accommodate two prisoners. The liaison officer told my investigator that the man had been the only occupant. Although unconfirmed at the time, the ligature used by the man was believed to have been a sock, secured to the bed.

6. Before leaving the prison, the investigator arranged to return at a later date to begin his investigation. He had identified a number of prison staff that he wanted to speak to, and agreed to return to the prison on 27 May to begin his work.

7. Following any death in prison, I publish a notice to staff and prisoners inviting anyone with information and who wishes to contact me to make themself known to the investigator. On 21 April 2008, Her Majesty's Chief Inspector of Prisons, Ms Anne Owers CBE, received a letter dated 17 April from a prisoner at Parkhurst. The prisoner began his letter by telling Ms Owers that he believed the man had been a victim of bullying on A wing. He went on to say he had spoken to the man who had told him he was

worried about his house and contents being seized. The prisoner did not say who was intending to seize the man's property. Although the majority of the prisoner's letter referred to matters unconnected to the man, Ms Owers arranged for my investigator to be given a copy of the letter, and it was received by my office on 19 May.

8. On 27 May, my investigator returned to the prison and over the next two days interviewed a number of staff. Unfortunately, not all those the investigator wanted to speak to were available and so he arranged to return later in the year to complete his interviews.

9. In the meantime, one of my FLOs had been in contact with the man's family. My FLO explained my role and offered the man's family the opportunity to meet her and the investigator. The purpose of offering the meeting was for the man's family to contribute towards my report and ask any questions they would like me to examine.

10. On 28 May, my FLO and investigator met the man's brother, sister-in-law and his two nieces at their home, where they were made very welcome. The man's family wanted to know why he had been moved from a secure mental health unit directly into Parkhurst and then placed into normal location and not the prison hospital. They asked if I could obtain an explanation for the decision to return him to prison and whether this was appropriate for someone with the man's mental health needs. They also asked whether the man was under the care of a psychiatrist within the prison. Additionally, they asked why the man had not been monitored by prison staff between 8.30am and the time he was found hanging.

11. The man's family told the FLO and investigator that they had attended a memorial service held for him at the prison. They added that two prisoners had told them that they had raised concerns about the man to prison staff. The family would like to know whether any action was taken in response. Additionally, the man's family said the prisoners told them that they would contact my investigators to tell them about their concerns. As at 28 May, the two prisoners concerned had not made contact with my office. The family later asked my investigator to try and speak to them, which he agreed to do on his next visit to the prison.

12. Before leaving Parkhurst on 29 May, my investigator gave feedback to the Governor about his findings at that point. The investigator told the Governor that he was concerned at the procedure adopted by an officer for unlocking cell doors at lunchtime. His concern was that the officer had simply unlocked the cell door, without first looking inside it, and then moved to the next cell and continued until the landing was fully unlocked. In the man's case it meant that he was not discovered at the earliest opportunity, and, had he still been alive, his chances of survival were thereby greatly reduced.

13. It would appear from discussions with prison staff that the way the officer unlocked the cell was common practice amongst the officers. The Governor accepted the feedback and told him she would meet with her management team the following day to discuss the issue.

14. On 21 July, my investigator returned to the prison to complete his interviews. Additionally, as he had had no response from prisoners to my previous notices, he arranged for new notices to be displayed around the prison. As a result, four prisoners responded and met my investigator.

15. Two days later, my investigator attended a serious untoward incident meeting at St Mary's Hospital. The meeting, set up to review the man's medical care, had been arranged by the IOW PCT because he had been in contact with mental health services in the two years before he died. It was a well attended meeting and included a number of specialist clinical staff, as well as the clinical reviewer commissioned by my office. In addition to discussing the man's medical history, those present considered the points raised by his family, which my investigator had asked them to do on the family's behalf. I have been pleased to learn that the family concerns were given full consideration at the meeting.

16. On 24 July, my investigator met the Governor and Head of Safer Custody. The purpose of the meeting was for the investigator to feedback his findings and likely recommendations. The Governor welcomed the feedback and agreed with the findings.

17. Following the prisoner's letter to Her Majesty's Chief Inspector of Prisons, my investigator arranged to meet him. However, the prisoner had been transferred from Parkhurst to HMP Rye Hill and it was not until 12 August that the investigator could find a convenient date.

Interviewees who have contributed towards the investigation

18. I list here those who have contributed to the investigation.

19. An officer that has been employed by the Prison Service for seven years. She has been an officer at Parkhurst for five years and, prior to this, was employed at another prison for two years as an Operational Support Grade (OSG).

20. The officer is an officer on A wing. She told my investigator that she first met the man when he was on remand at Parkhurst on a previous sentence. She described the man as being at that time a "difficult prisoner and a nuisance". She said he was not in any way threatening, but more mischievous than anything else and that he was always trying to find ways to leave his cell. At interview, the officer said that on one occasion the man, who had been held on remand, had been given a custodial sentence and had not returned to Parkhurst. Instead he had been transferred to HMP Winchester as a sentenced prisoner, where he remained until being

transferred to HMP Albany and later to HMP Camp Hill to continue his sentence.

21. The officer told my investigator that soon after receiving his sentence the man began writing to her. In his letters, he asked her to look after his bicycle and to go to a local cycle store to purchase items on his behalf. The officer reported the matter to the prison's security department and they in turn arranged for any further correspondence from the man to the officer to be stopped.

22. The officer said she received no further letters from the man whilst he was at Winchester. However, when he later transferred to Albany he attempted to write to her again. This time the security system at Parkhurst prevented the letter from reaching her. Although she did not see the letter, the officer believes he was asking her to do the same as in his previous letter.

23. Once again the man moved prisons, this time to Camp Hill. The officer said he tried again to write to her, but as before the letter was intercepted and did not reach her. It would appear from what the officer was told by a member of the prison security department that the man had been asking her to look after his bicycle and to purchase cycle equipment for him.

24. A second officer is an officer based on A wing. He is also a member of the prison care team. (The care team help and support prison staff and are available to any member of staff.)

25. A senior officer was the wing manager on 14 April. He has been employed by the Prison Service for nine years. He began his career as an Operational Support Grade (OSG) before becoming a prison officer in 2000. In April 2004, he was promoted to senior officer (SO).

26. The senior officer told my investigator that he had known the man for a few years and had first met him when he had been in the prison on a previous sentence. He described the man as someone you could not help liking, but one who was constantly demanding the attention of staff. The senior officer said the man was quick to apologise whenever he did things wrong and, in his opinion, never fully realised the seriousness of his situation.

27. A third officer is one of the A wing officers. She has been employed by the Prison Service for 17 years. On 21 March 2008, the officer made a significant entry in the man's prison file about his behaviour.

28. A fourth prison officer has been an officer for less than one year. He joined the Prison Service at HMP Albany as an OSG in early 2007, and then transferred to Parkhurst in July the same year to begin his prison officer training. The officer was the member of staff who discovered the man hanging.

29. An art teacher who works four days per week at Parkhurst and one day at Camp Hill. The teacher told my investigator she had known the man for a few years and described his behaviour on his previous sentence as "unmanageable and someone to be avoided at all costs". She said he was not physically threatening, but he would make inappropriate sexual remarks to female staff. She said that, since returning to prison on remand, the man had been a completely different person to that which she had witnessed previously. The teacher spoke briefly to the man on 14 April, a few hours before he was found dead.

30. A Registered General Nurse (RGN) has been a qualified nurse for 37 years. She has been employed by the Prison Service for eight years. On 14 April, the RGN responded to a request for medical assistance and assisted another nurse with resuscitation.

31. A Hospital Officer (HO) has been employed by the Prison Service for 17 years. For the first 11 years he was an officer and then became a healthcare officer in 2002. In March 2008, he reverted back to being an officer, but remained in healthcare in a supervisory capacity. For the purpose of this report I refer to him as the hospital officer.

32. The hospital officer told my investigator that he had known the man from a previous sentence. He described his behaviour at that time as being a "nuisance and very demanding", but not threatening or aggressive. In contrast to this description, he said that since the man had returned to Parkhurst in March 2008 he had been a different person. He said he kept himself to himself and was not seen in healthcare very often.

33. A fifth officer has been employed by the Prison Service since February 2008. After completing his officer training, he returned to Parkhurst as a qualified prison officer on 13 April. At the time of the man's death, he was only on his second full day as an officer.

34. The duty governor on 14 April has worked in the Prison Service for ten years. The duty governor began his career as an officer at Winchester. After this he worked at HMP Ford, Prison Service Headquarters, and HMP Wandsworth. He is currently employed at Parkhurst as the Deputy Head of Offender Management.

35. A prisoner who has been at Parkhurst since January 2008 occasionally spoke to the man. The prisoner described the man as a quiet man, which he said he knew to be the opposite of his reputation. He said that he and the man began talking to each other and that the man had been upset at being back in prison. The prisoner said the man had told him that he was particularly upset at having split up with his wife and children, although he did not know when this had occurred. Although apparently unhappy at the breakdown of the relationship, the prisoner said the man appeared to be happy in prison and not isolated, which is what the man had said was how he felt in the community. The prisoner said that about one week before he died, the man had been noticeably happier than he had been previously.

36. A second prisoner has been at Parkhurst since August 2006 and knew the man well. The prisoner told my investigator that he had known him from a previous prison sentence, and described him then as being “erratic, and a problem for prison staff”. He went on to say that when he next saw the man in March 2008 he was a different person, describing him as quiet, withdrawn and reflective. The second prisoner said the man once asked him if he knew anything about probate and death duties. He told my investigator that he was concerned about the man’s attitude and had spoken to the first officer about these concerns.

37. A third prisoner has been at Parkhurst for over two years. He has provided background information about the man. At the meeting with my investigator, the prisoner said the man had been “different” since returning to prison and that he was subdued. He said they often spoke to each other, but the conversations were not specific and were more general passing comments. He said he was not aware of anything bothering the man and, at no time, did he ever suggest that he was planning to end his own life.

38. A fourth prisoner at Parkhurst has been at the prison for about 18 months and has provided background information about the man. He told the investigator that the man had said he felt frustrated at restrictions that had apparently been placed on him, preventing him from seeing his family. The prisoner said the man felt “trapped”. My investigator has been unable to establish what restrictions he was referring to.

39. The fourth prisoner told my investigator that he had previously been a Listener at HMP Pentonville. (Listeners play an important part in supporting prisoners identified of being at risk of suicide and/or self-harm. They are trained, selected and supported by Samaritans to offer confidential emotional support, 24 hours a day, to fellow prisoners in distress.) He said that, although the man was allocated to the vulnerable wing, he did not feel that he was suicidal. However, he thought that the man might harm himself but not with the intention of ending his life. My investigator asked the prisoner if the man had ever said he was going to kill himself, but he said that he had not.

HMP PARKHURST

40. HMP Parkhurst is one of three prisons situated on the Isle of Wight, close to the town of Newport. Originally built in the Nineteenth Century, it has undergone extensive refurbishment. Accommodation is provided for sentenced male prisoners, although there are a small number of cells available for remanded prisoners.

Assessment, Care in Custody and Teamwork (ACCT)

41. ACCT requires staff to identify any concerns, take action, and document those actions for prisoners identified as at risk of suicide or self-harm. The ACCT document should be available to all staff where the prisoner is located. Within 24 hours of the document being opened, the at-risk prisoner will be seen by an assessor and have a case review meeting. The meeting draws up a care and management plan, known as a CAREMAP, and a member of staff is nominated as the case manager. Wing managers take on the role of case manager, oversee the management of the ACCT document and attend case reviews.

Anti Ligature Knives

42. Staff in contact with prisoners are issued with specially designed anti ligature knives, commonly referred to as “fish knives”, which are used in an emergency to remove a ligature. The knives have a concealed blade which is placed against a ligature and which can be pushed forward to cut it without harming the prisoner.

Care Team

43. Each prison has its own care team. Care team staff are drawn from all areas of the prison and trained specifically to help and support prison staff. Following any serious incident, they provide an invaluable role to any member of staff who requires support.

Control room

44. Parkhurst has its own control room. The room is equipped with video monitors showing pictures of the prison perimeter, telephone facilities and a radio system. The prison radio call sign is Papa Tango. All other users of prison radios are given their own individual call sign.

45. One of the facilities available in the control room is the ability to record radio conversations. The information can be downloaded, providing an accurate timeline of events.

46. The prison radio communication system is normally on “closed net”. This means that the radio operator in the control room can hear all radio transmissions, but the individual staff with handsets cannot. The only transmission they can hear is anything transmitted by the control room

radio operator. However, the system allows for the radio net to be placed on “talk through”. Under talk through conditions, everyone with a radio can hear the full transmissions and not simply the transmission made by the control room radio operator. Talk through is automatically switched on during an emergency situation, as it allows everyone with a radio to be aware of what is happening. It is only switched off when the situation has been resolved.

Duty Governor

47. The duty governor is the first point of contact in the event of a serious incident. Whenever the duty governor is in the prison, he or she carries a prison radio, with call sign Victor three. Outside of these times the duty governor is contactable 24 hours per day by telephone or pager.

Emergency response codes

48. In the event of urgent medical assistance being required, a number of prisons have chosen to adopt codes to alert medical staff to particular incidents. The most common codes used are code red and code blue, although some prisons have opted for code one and code two.

49. Code red or one informs the medical staff that the patient is bleeding. Code blue or two alerts them that the patient is in breathing difficulty. In prisons where codes are used the healthcare departments have created emergency response bags which contain the necessary equipment to deal with the particular incident. This ensures that medical staff take the correct emergency equipment with them and helps provide the necessary medical care as quickly as possible. However, Parkhurst does not have a code system and instead relies on staff simply saying what the emergency situation is.

Independent Monitoring Board

50. Each prison has an Independent Monitoring Board (IMB) whose role is to monitor and to report any concerns that they have regarding the prison, or how prisoners are treated. Board members are able to visit any area of the prison at any time and have direct access to any prisoner who they wish to see, or who requests to see them. The Board holds monthly meetings in the prison, with the Governor attending for part of the time. The Board produces an annual report for the Secretary of State for Justice.

Unlocking cell doors

51. Before unlocking, opening or entering a cell, the person unlocking the door should first of all look inside through the observation panel and check where the prisoner is. The reason for this is to prevent causing injury to the prisoner, who may be directly behind the door, and to ensure the prisoner is not armed.

Police investigations of deaths in custody

52. With all deaths in prison custody, the police are notified as soon as the death has been discovered. In the first instance, the police treat the area where the person is found as a potential crime scene and, as part of their investigation, note the names of everyone involved and those who have been in contact with the body. Additionally, they note the identity of all those entering and leaving the cordoned area. It is only when the police are satisfied that the death is not suspicious that my investigators are able to begin their own investigations.

Prison officer grades

53. There are three levels of uniformed prison officer grades. Prison officers are the front-line supervisory staff and, in the majority of cases, prisoners have first and most contact with them.

54. Senior Officers (SOs) are the first grade of managers and act as a reference point for prison officers. SOs are responsible for the day-to-day management of their area, supervising staff and dealing with issues raised by prisoners.

55. Principal Officers (POs) are the highest rank of the uniformed staff. They supervise other uniformed staff and have operational responsibility for the prison.

56. In addition to prison officer grades, there are a group of staff known as Operational Support Grades (OSGs). OSGs wear prison uniform and carry keys but do not carry out the same function as prison officers. Their role is to support the areas of the prison where there is little or no prisoner contact, for example, the gate.

Her Majesty's Chief Inspector of Prisons

57. Her Majesty's Chief Inspector of Prisons, Ms Anne Owers CBE, reports on all Prison Service establishments. The majority of inspections are pre-announced and allow the prison to prepare for inspection. However, a number of inspections are carried out without prior warning and are known as unannounced inspections.

58. In July 2005, the Chief Inspector carried out an unannounced inspection of Parkhurst. In the introduction to her report, Ms Owers said it was pleasing to record improvements from three years earlier, but added that the jail still had some way to go to be an effective training prison.

59. Ms Owers' report said that mental health services were at an early stage of development and were commissioned by the PCT from Hampshire Partnership Trust. She went on to say that there was some good work carried out by the psychiatrist and his team regarding their approach to the future management of psychiatric prisoners at Parkhurst.

60. However, one recommendation was made in relation to mental health provision. The recommendation was that, “Mental health services should be developed to meet identified needs, including occupational therapy and day care provision.”

FINDINGS

January – 11 December 2007

61. Prison records show that imprisonment was not a new experience for the man. His previous custodial period began in January 2007 and ended on 11 December when he was released from HMP Camp Hill. The clinical reviewer notes that the man was seen by a prison doctor in January when he went into prison, although she does not say who saw him. The doctor is said to have believed that the man might have had a learning disability with "impulse control" and so had requested a psychiatric assessment.

62. The review notes that in response to the doctor's request, the man was seen by the Prison In-Reach Team. The reviewer has not identified any mental health problems, but does note "poor impulse control" and "personality traits". (The review does not say what the impulse control or personality traits were.)

63. The reviewer notes that at some point in August 2007 prison staff asked the In-Reach Team to see the man again, although she does not say why. It would appear from the reviewer's report that the man had told the In-Reach Team that he was sleeping well and had talked about his pending court case. The In-Reach Team had noted that the man had been writing inappropriate letters to females, but he (the man) felt that he had done nothing wrong.

64. On 22 November, the man was interviewed at Parkhurst by a Consultant Forensic Psychiatrist. The reviewer notes that the forensic psychiatrist had described the man as "unkempt, with pressure of speech, peeling skin and chronic hypomania". Knowing that the man was due to be released on 11 December, he asked for a more detailed assessment of his medical condition. Discussions took place between prison medical staff and IOW PCT to accommodate the man in Seagrove Ward following his release from prison. The In-Reach Team discussed the transfer to Seagrove Ward with the IOW PCT, and staff there felt that the man could be managed on the ward and were content to admit him.

65. In the meantime, arrangements were being made by police to arrest the man as soon as he was released from prison. (It is not known whether medical staff were aware of the police intentions, or whether the police were aware of the medical staff intentions.) On 11 December, after being discharged from Camp Hill, the man was immediately re-arrested outside the prison and taken into custody where he was charged with "Harassment and Breach of an Anti Social Behaviour Order" (commonly referred to as an ASBO).

12 December 2007

66. On 12 December, after a brief appearance at court, the man was remanded into prison custody and taken to HMP Winchester. When he arrived there, he went through the normal routine for receiving prisoners into custody, and staff did not identify any suicidal concerns.

67. Because of the forensic psychiatrist's earlier request for a more detailed assessment of the man's medical condition, and in order to complete the medical assessments arranged prior to his re-arrest, the man was transferred on 11 January 2008 to Woodhaven Secure Unit as the Seagrove Ward had no beds available. This unit is part of Hampshire Partnership NHS Trust. However, a bed space was identified at Seagrove Ward and, on 4 February 2008, the man was transferred there.

68. At the panel review meeting, a Consultant Psychiatrist reported that when she saw him in Seagrove Ward the man's speech was less pressured. He told her he did not like taking his medication, adding that he "bitterly resented" having to take it. The doctor said she agreed with the man that he could stop the medication but expected him to become "hyper". However, the doctor told the review panel that the man became more settled once he had stopped the medication. The consultant psychiatrist told the panel that she could find no evidence of inappropriate sexual behaviour towards women and that the man had not expressed any suicidal tendencies to her.

69. In her review report, although the date is not recorded, the reviewer says that it had been suggested to the man by medical staff that he might want to have an HIV test, which appears to be standard procedure, and something which he agreed to. From what can be determined, the test was a self referral by the man, and was carried out by the IOW Genito-Urinary Medicine Clinic (GUM). (There is no suggestion that the man was suspected of having HIV.)

70. After completing their assessment, his doctors felt that he no longer required hospital intervention. Because the man was a prisoner, discussions took place between medical staff at the hospital and the Ministry of Justice to consider where best to place him. At a hospital discharge planning meeting, attended by the prison In-Reach Team, it was agreed by those at the meeting that the man should be returned to prison custody, with the contingency that, should he require it, a place would be available for him in Seagrove Ward.

71. In the meantime, while the man had been in hospital, his criminal case had been transferred from Portsmouth Crown Court to Newport (IOW) Crown Court. As Newport Crown Court falls within the catchment area of Parkhurst, arrangements were made to transfer him to Parkhurst as it would be easier for him to attend court.

March – 13 April

72. On 6 March, the man was transferred from Seagrove Ward to Parkhurst as a remand prisoner. When he arrived at the prison, he repeated the normal reception procedures, which did not identify any issues relating to the man's safety, or any concerns that he might harm himself. Because he no longer required ongoing medical intervention, the man was not admitted to the prison hospital. Instead, he was treated as a vulnerable prisoner because of his age and was allocated to A wing, the vulnerable prisoner wing. (Vulnerable prisoners are usually kept separated from mainstream prisoners for their own safety, either as a result of their offence, vulnerability, or age.)

73. Twelve days later on 18 March, the man was assessed at the prison by Consultant Forensic Psychiatrist. At that consultation meeting, the doctor noted that the man was "a little low and concerned about the future". The doctor discussed medication with the man, but he said he did not want to take any. The forensic psychiatrist told the review panel that the man acknowledged that he might have had a "break down". (The review panel did not note which period the doctor or the man was referring to.)

74. The first officer told my investigator that she next saw the man when he returned to Parkhurst on remand. At interview, the officer said she was not on duty when he arrived at the prison, and that it was a few days afterwards when she met him again on A wing.

75. My investigator asked the first officer to describe the man's behaviour on this occasion. She said he was very different, explaining how quiet he was and how he would remain in his cell. This was in complete contrast to his previous time at the prison. The first officer went on to say that she was concerned about the man and decided to speak to him. She added that the concern was not from a suicidal or self harm perspective, but more about why he was so different.

76. When the first officer spoke to the man, he told her how he had come to realise how bad he had been to his parents. He also expressed regret at his behaviour towards her and other prison officers.

77. Despite having no concerns that the man had suicidal ideas or thoughts of self harm, the officer asked if he felt like harming himself. She told my investigator that he told her that he had never harmed himself and had no intention of doing so. After speaking to the man, the officer telephoned a manager in the prison security department and told him about her conversation.

78. The first officer told my investigator she had no further dealings with the man other than in passing when she would say hello and ask him if he was okay. She said he would acknowledge her and tell her that he was fine.

79. When my investigator met the officer, she was accompanied by a colleague, a second officer. The second officer told the investigator that he had not known the man previously and only met him in A wing. He described the man as a polite man, and someone who would take the time to have a conversation with prison staff. He added that the man did not make any demands on staff.

80. On 21 March 2008, a third officer made an entry into the prison computer system about the man. At interview, the officer said she had known the man for a number of years and described him as a happy character who constantly wanted to talk. She described him as impulsive.

81. The third officer said she had noticed a change in the man's behaviour and had decided to speak to him. The officer said when she sat with the man he was tearful and told her that he did not know what was happening with his case. She told my investigator that the man said someone had told him he could be facing further charges and returning to prison.

82. The third officer said she asked the man if he felt suicidal, but he said he was not, adding that he would never do anything like that. She suggested he speak to the prison doctor, but was not sure whether he had done so. My investigator asked the officer if she was concerned about his safety, and she said she was not. She added that the man was impulsive and that she believed he made a snap decision to end his life.

83. It had been suggested to my investigator by a prisoner that the man might have been in debt. My investigator asked the third officer if the man had mentioned anything to her about debt. She said he had not and that the man had told her he was adopted and had been left a lot of money by his parents. The officer added that he was extremely remorseful about his past.

84. The senior officer told my investigator that he was aware that the man was back in prison, but did not see him until about two weeks before he died. He said that, when he did meet him, there was a noticeable change in his behaviour. He remembered the man telling him that he was going to change his ways.

85. The senior officer said the man appeared to have matured in that he was less demanding and more understanding of the wing routine and rules. He said when the man first arrived into A wing he was in a double cell, sharing it with another prisoner, but the other prisoner had been discharged and left the prison. The senior officer described the two men as a "double act," and that it was the other prisoner who made demands on staff time rather than the man.

86. The senior officer said he and the man would talk occasionally. My investigator asked if the man ever discussed anything to do with his property being seized. The senior officer said he had not. He went on to say that the man had told him that he had a number of cars on the Isle of

Wight which he had left at the homes of friends and something that he (The man) “needed to sort out”.

87. My investigator asked the senior officer if bullying was a problem on A wing. He said in addition to A wing holding vulnerable prisoners, a few prisoners had been allowed to live there for their own protection. The senior officer said some bullying had taken place, but it had not in any way involved the man. He said bullying incidents had been investigated at local level and dealt with.

14 April

88. At about 7.45am, a fourth officer started duty on A wing. His job that day was to supervise the wing cleaners and arrange the collection of prisoner meals. The officer said at interview that he had not known the man very well. He said the man was someone who kept himself to himself, although he said he was aware from other staff how different the man was from his previous sentence. He described the man as a happy person and not someone who looked unhappy.

89. The first prisoner told my investigator that he remembered seeing the man during the morning exercise period. He described the man that morning as “bouncy” and appearing to be much happier than normal. The prisoner said his impression was that the man was reverting to how he used to be. He added that there was nothing to suggest what the man was planning to do shortly afterwards.

90. At interview, the teacher said that at about 8.15am she walked across the exercise area of A wing, making her way to the education department. She said she noticed that the man was walking and talking with another prisoner. The teacher said she stopped briefly to speak to the man about the weather and asked him how he was. The man commented on the weather, said he was fine, and carried on walking. The teacher said she saw nothing to suggest that anything was concerning the man. She told my investigator how she remembered being pleased that the man was mixing with other prisoners, adding that it was not something he had done previously. The teacher added that her route to the education department took her through A wing, and that she had passed comment to an officer about the change in the man’s behaviour. The teacher said she did not see the man again.

91. The senior officer told my investigator that he was the wing manager that morning, adding that he was not the regular manager on A wing. He said that, at about 8.00am, prisoners were unlocked to take exercise in the fresh air. The senior officer added that, although he did not know it at the time, he had since learnt that the man had been out on exercise, and that this had apparently been an unusual event for him.

92. The second prisoner told my investigator that he had walked with the man during the exercise period that morning. He said the man had told him that he had let his brother down and wished he could turn the clock back. The second prisoner said he had suggested to the man that he could contact his brother, but the man said "I have no time left." The prisoner added that, before leaving the exercise area, he offered the man a newspaper but he declined the offer saying that he did not need it. The prisoner said this was unusual, as the man would normally take a newspaper to his cell, but he did not think anything more of it.

93. At the end of the exercise period, the second prisoner saw the man return to his own cell and close the door behind him. My investigator asked the prisoner if the man had ever suggested that he was going to harm himself or end his life. He said he had not.

94. The third prisoner told my investigator that he had seen the man take exercise that morning and believed he did not stay until the end of the period. He said they spoke briefly to wish each other good morning, and that there was nothing to suggest that anything was bothering the man.

95. At the end of the exercise period, which was at about 8.30am, the man returned to his cell, A 2.25, and was locked up for the remainder of the morning. From what can be ascertained, this was probably the last time that he was seen alive.

96. The senior officer said that at the end of the exercise period all prisoners returned to the wing. He added that, with the exception of those going to work off the wing or to education classes, the remaining prisoners were locked in their own cells. He said that these prisoners, including the man, would not be unlocked again until lunchtime.

97. At about 11.15am, the fourth officer left A wing with three prisoners to go to a central point to collect the lunchtime meals. The officer described to my investigator how prisoners are able to pre-select their meals in advance and, when he collects the meals, the various choices are on a heated trolley ready for him to take to the wing. Once the meals had been collected, the officer returned to the wing and placed the food into the servery compartments, ready for prisoners to collect it.

98. About 15 minutes later, the officers began unlocking prisoners to allow them to collect their lunch from the wing servery, situated on the ground floor of the wing. Although it is not absolutely certain who unlocked the man's cell, my investigator is satisfied that in all probability it was the fifth officer, as the other two officers appear to have been carrying out other duties.

99. The fifth officer told my investigator that he had been a fully qualified prison officer for about 24 hours and that this was only his second shift on duty. He said he was not 100 per cent certain that he unlocked the man's cell, but believes it to be a strong possibility. The officer had no specific

recollection of the man, and the only prisoners he could remember were those being monitored under the ACCT arrangements. The officer confirmed that the man did not fall into this category.

100. At interview, the fifth officer said he had no reason to go to the man's cell during the morning and the first time he did so was when he unlocked the doors at lunchtime. He described how he walked along the landing, unlocking the doors and opening them slightly, without looking into the cells. The officer said that, once he had unlocked the doors, he then went to the third landing to deal with an unrelated matter.

101. In the meantime, as the officer responsible for issuing meals on A wing, the fourth officer was supervising prisoners collecting their meals from the servery. He told my investigator that he had a board listing all of the prisoners' names on A wing, along with their individual pre-selected choices. He added that, as each prisoner collected a meal, he ticked off their name. With the exception of the man, all prisoners collected their meals.

102. After tidying up the servery area, the fourth officer decided to go to the man's cell to see why he had not collected his meal. He said it was unusual for the man not to have done so, and so at about 11.50am he went to his cell to check for himself. When he arrived at the man's cell, the door was partially open and he went inside. At the same time as he was opening the door, the fourth officer began talking in case the man might not be aware that he was there or was using the toilet.

103. When the fourth officer went into the cell, he saw the man on the left side of the cell with a ligature around his neck that had been secured to the top section of the bunk bed. In interview, he said he remembered seeing a chair underneath the man and believes he was not sitting on it. The man was white and still. The fourth officer said he immediately left the cell to obtain assistance. The prison radio log shows the time of the officer's first radio message was 11.55:38am.

104. At about the same time, the senior officer was told by a prisoner that the fourth officer was trying to attract his attention. At interview, the senior officer said that when he looked towards the officer he saw him waving to him, beckoning him to go to him. Realising that something was wrong, the senior officer went immediately to the officer who was unable to speak and was shaking at the time, pointing into the man's cell. The senior officer said he went into the cell expecting to find blood. However, when he entered the cell, he saw the man in a seated position on a chair, with his back to the bed. He saw a black ligature around his neck, attached to the bed frame.

105. The senior officer said the man's complexion was grey and that he looked as if he was asleep. He lifted the man from his chair, and in doing so touched his skin which was cold. He added that the ligature was extremely tight into the man's neck and, when he tried to remove it by

using his anti ligature knife, he was unable to control his hand as he too was shaking. The senior officer said he realised that the man had died and for a few seconds he was so shocked he “sat and cuddled him”. He said he then regained his composure and, because he was unable to do anything for the man, left the cell to use his prison radio and asked for urgent medical assistance and an ambulance. The radio log shows that at 11.56:01am, the senior officer said “urgent, urgent message”, but at that point he did not ask for medical assistance. This was followed by the radio operator placing the radio system into talk through and announcing that there was an alarm bell on A wing and that assistance was required.

106. One of the people who acknowledged the message was the duty governor. At 11.56:56am, he asked for immediate medical assistance. As the radio system was on talk through, a member of healthcare heard the message and acknowledged the request at 11.57:10am.

107. At 11.57:20am, the duty governor told the radio operator that no more staff were required. Believing that the incident was over, the radio operator followed the correct radio procedure and removed the talk through facility, returning to normal radio transmissions.

108. Thirty eight seconds later, at 11.57:58am, the duty governor used his prison radio and asked for healthcare staff. Because the radio system was no longer on talk through, no one other than the radio operator could hear his transmission, and his message was interrupted by the senior officer who was asking for an ambulance. The radio operator asked the duty governor to repeat his message, which he did. On this occasion he asked for healthcare staff to go immediately along with resuscitation equipment.

109. At interview, the hospital officer said that, shortly before the control room issued the message for medical assistance, he had been approaching A wing along with a prisoner who he was escorting to the wing. As he was about to enter the wing he heard the radio message and immediately went to the cell where he met the senior officer.

110. The senior officer said he went back into the cell when the hospital officer arrived. He said they both went into the cell and, whilst supporting the man’s weight, the hospital officer took the anti ligature knife from the senior officer and cut the ligature from his neck.

111. The senior officer said the hospital officer checked the man’s pulse, but could not find one. He said the hospital officer was unable to start cardio pulmonary resuscitation (CPR) straightaway as he did not have a mouth guard. However, a guard was given to him by a member of staff and CPR was started and continued until paramedics arrived.

112. The hospital officer said he entered the man’s cell and saw him in a half seated position. He saw a piece of black material around the man’s neck, with one end attached to the bed frame. The hospital officer said the

man's skin was yellow and his eyes were open and opaque. He checked for a pulse but did not find one. He added that the man's skin was cold.

113. At 12.01:30pm, the radio operator told the duty governor that the ambulance had arrived at the prison gate. The radio log shows that, within one minute of it arriving at the prison, it was escorted to A wing.

114. The hospital officer said he was joined by the nurse. She took over the CPR breathing, whilst he carried out chest compressions and at some point he used his radio to ask for a defibrillator. The radio log records the time that the defibrillator was requested as 12.04:06pm.

115. The nurse told my investigator that, when she arrived at the cell, she saw the hospital officer giving the man mouth to mouth resuscitation. She assisted by taking over the breathing, whilst the hospital officer carried on with chest compressions. The nurse said that both she and the hospital officer continued with CPR until ambulance staff arrived and took over. She said she saw them attach electro cardiograph equipment to the man, but did not see what the result was. The nurse left the cell to allow the paramedics to work, but did go back in the cell on two occasions to offer assistance (which was not required).

116. The nurse said that the man was in a collapsed state, not breathing, and was clammy, grey and cold to touch. She said the man had no pulse and that his pupils were dilated. My investigator asked if rigor mortis was present, but she said it was not.

117. In the meantime, a second ambulance containing paramedics arrived at the prison. The radio log shows that it was escorted to A wing at 12.08:13. They assisted the ambulance staff and, after carrying out their own checks, they confirmed that the man was dead.

After the man's death

118. Following the man's death, two members of the prison's IMB were on hand to support staff and prisoners. One of the members had been in the prison at the time the man was discovered. The other member was there as a result of the prison notifying the duty IMB member of the man's death. (Although strictly speaking the role of the IMB is to monitor not to intervene, I think the offer of support at such a time was a simple human kindness.)

Staff care

119. Having left the cell to allow medical staff to care for the man, the senior officer moved the fourth officer away from the area. The officer said he was taken away from the cell by a member of staff, but could not remember who it was. Soon after leaving the area, and on the instructions of a senior manager, the officer was taken home.

120. The fourth officer told my investigator that the support for him had been good. He said he returned to work two days later, but for approximately one week he was allocated to a different wing.

121. My investigator asked the nurse about the support for staff. She said the support had been very good, adding that prisoners were also well supported by prison staff.

122. The deputy Governor said she had been to A wing where she had remained for some time, and had also issued a notice to prisoners and prison staff telling them that the man had died. She arranged for members of the prison care team to be available to any member of staff requiring support. The prison chaplaincy team were also available to support both staff and prisoners.

123. Later that afternoon, and in line with Prison Service policy, the deputy Governor arranged for a hot de-brief to take place. The meeting which took place at about 5.30pm was attended by the majority of staff who had been involved.

124. Although not a mandatory instruction, the Governor arranged for a critical incident de-brief to take place. On 6 May 2008, a number of staff attended the debrief and were able to speak in confidence about the events of 14 April.

Care for prisoners

125. Following the man's death and in line with procedure, the deputy Governor arranged for all prisoners who were being monitored under the Prison Service's Suicide and Self Harm arrangements to be reviewed. The senior officer said that when staff checked the prisoners, one man, who he described as having a prolific history of self harm, was found with a ligature in his hand. He said that, after taking the ligature from the man, staff sat with him for some time and offered support. Shortly afterwards, an urgent review was carried out and an appropriate support plan put in place for the prisoner concerned.

ISSUES

Unlocking prisoners

126. My investigator contacted the Prison Service officer training department and confirmed that prison officers are given specific training in how to unlock a cell door. The training instructor told the investigator that officers are told to open the cell door observation panel and look inside whenever they unlock a cell door and before entering. In this way they can determine where the prisoner is and assess whether it is appropriate and safe to enter at that time. Additionally, the officer can see immediately whether assistance might be required before entering the cell, for example if the prisoner is armed or ill and in need of medical assistance.

127. We know that the officer who unlocked the man at lunchtime did not look into his or any other of the cells on the landing. Given that he had just undergone extensive training to be an officer, this is surprising and disappointing. I am satisfied that the man was not being specially monitored and therefore there was no requirement for officers to have seen him any earlier than lunchtime. However, there has to be an expectation that at the point of unlock the man should have been seen.

128. When my investigator observed the procedures for unlocking cells, he saw other officers carrying out the same actions as those described by the fifth officer (in contrast to those expected by the Prison Service training officer). Why the fifth officer adopted such a practice so soon into his career is not known, but I suspect he was simply following what other officers were doing. Sadly, the officer's actions meant that the man was not discovered at the earliest opportunity. My investigator raised the finding immediately with the Governor. My investigation has been unable to establish whether, at the point of unlock, the man was still alive and this will probably be a matter that the Coroner and Governor will wish to consider.

The Governor should remind all staff of the correct procedure for unlocking and opening a cell door.

Request for medical assistance

129. At interview, my investigator asked the hospital officer how healthcare are alerted to a medical emergency. He said requests were usually made by the control room via the prison radio system. The hospital officer said the main problem with the radio communication was that healthcare were not always told what the emergency was, and often attended incidents not knowing what they were going to deal with or having the correct equipment.

130. My investigator asked the nurse the same question. She said that the majority of urgent requests were made via the prison radio, although on occasions they were made via telephone. The nurse said that, in general, once a call has been received, healthcare staff will go to a patient without

knowing what it is they are attending and without emergency equipment. She went on to say that emergency equipment is available in a "grab bag" which contains items such as bandages, blood sugar equipment, glucose, blood pressure equipment, and suction equipment. She added that new oxygen equipment was available and also a defibrillator, but these items were not in the grab bag.

131. I have in a number of my reports identified as good practice the adopting of a code system for alerting healthcare and prison staff to specific medical emergencies. In this way, healthcare has been able to respond with the appropriate medical equipment. The most common codes appear to be code blue and code red, although there are other examples. My investigator found that Parkhurst does not have such a system.

132. Having read this report, it is immaterial whether the Governor decides to use codes or simply encourages staff to say exactly what the situation is. (I have made my preference for codes known above.) The important issue is that healthcare staff should know immediately what the emergency situation is that they are being asked to respond to. Additionally, prison staff should be able to request medical assistance and be confident that their message has been understood and is being dealt with appropriately.

133. I am satisfied that, by the time staff found the man, it was too late to effect resuscitation and the use of a code system would not have made any difference to the sad outcome. However, in another case, it could be quite a different scenario and time could be wasted by having to request resuscitation equipment. For this reason, I urge the Governor to consider how to ensure that medical staff know what the situation is at the earliest opportunity.

The Governor should consider how best to ensure healthcare staff know immediately what type of incident it is they are being asked to attend.

Emergency medical response equipment

134. Emergency medical equipment is readily available in healthcare and should be taken to any medical emergency. On this occasion it was not. I am satisfied that in the man's case the equipment was probably of no use, but in another case it could have been the difference between life or death.

The Governor in partnership with the PCT should ensure that whenever urgent medical assistance is required, the emergency grab bag is taken to the patient immediately.

The Fourth Officer

135. Prison officers deal with many difficult prisoners and situations and the fourth officer could have been forgiven had he simply thought that the man did not want lunch and done no more about it. Instead, realising that it was unusual for the man to miss a meal, he took a proactive decision and went to his cell to check for himself. At this point, he discovered the man.

136. The fourth officer could do nothing for the man, but his decision to check on the welfare of a prisoner was commendable. I invite the Governor to share my comments with him and to consider if any formal recognition of his actions would be merited. I certainly regard his actions as good practice.

ACCT Reviews

137. Following the man's death, and in line with the correct procedures following a death in prison, officers checked all prisoners on A wing. In particular, they ensured that those prisoners being monitored under ACCT were safe.

138. When officers checked the prisoners, one man with a long history of self harm was found in possession of a ligature. The officer who made the discovery took the ligature from the prisoner and sat with him for a while to support him. An urgent review and reassessment of the prisoner was carried out, along with a support plan.

139. I have been delighted to learn that Prison Service instructions to review all prisoners being monitored under ACCT were carried out so promptly. We cannot know what the prisoner intended to do with the ligature, but it has to be a distinct possibility that a life was saved by the swift actions of prison staff.

140. I am satisfied that the correct actions following a death in custody were carried out promptly and effectively. The actions of prison management and staff are an example of good practice.

Critical Incident De-brief

141. Although at the time the Governor was not required to facilitate a critical incident de-brief, I have been pleased to learn that she did. In a number of my reports, I have commented on the value of such meetings. I welcome the Governor's actions in supporting her staff and view the de-brief as good practice.

Clinical Review

142. The clinical reviewer says that in his view the quality of healthcare given to the man was good and equivalent to that provided in the community. In response to a question from my investigator who wanted to know if the

man could have been bullied by other prisoners for his medication, the clinical reviewer comments on the results of the post mortem report. He says that tests carried out after the man's death show that he had not been prescribed any medication, and that there was no evidence of over the counter remedies, drugs or alcohol in his blood. The clinical reviewer doubts whether the man could have been subject to bullying for medication, as he had not been issued with any.

Review of Unexpected Death and Serious Mental Health Untoward Clinical Incidents by Isle of Wight PCT

Clinical Care

143. My investigator asked the panel a number of questions relating to the man's medical care, some of which were raised by his family. The panel were asked to clarify the process that supported the decision to transfer the man from Seagrove, Sevenacres Ward to Parkhurst. The panel was also asked about the communication between Sevenacres Ward, St Mary's Hospital, Newport IOW and the prison concerning the man's needs, and whether his needs were met.

144. The reviewer said the team at Sevenacres and the prison considered the man fit to be moved back to prison. The Department of Health and the Ministry of Justice guidance states that a discharge planning meeting should be arranged before the patient is transferred. This meeting was arranged and involved the staff at Sevenacres and the prison. The Responsible Medical Officer (RMO) wrote a report to the Ministry of Justice to inform them that the man was no longer suffering from a mental illness. The consultant psychiatrist (RMO) and the forensic psychiatrist assisted with the process. The reviewer said that the Ministry of Justice will always ask that the prison has been involved in the process before issuing a warrant for transfer, and she confirmed that national guidelines had been adhered to in the team's decision to transfer the man.

145. The Access and Acute Lead, made the point that, if the man had not been a prisoner but had been in the community, his mental state was such that he would have been managed on an open ward or even under the care of the Home Treatment Team. It was because he was a prisoner that he was cared for on a secure ward.

At the time of the man's death, which professionals were involved in his care?

146. The reviewer said that, at the time of the man's death, the Prison In-Reach Service, the Community Psychiatric Nurse and his Forensic Consultant were involved in his care.

What processes are in place to ensure that, whenever prisoners express concern for another prisoner, those concerns are acted upon, and was this done on this occasion?

147. Whenever concerns are raised about a prisoner, prison staff have a number of options open to them. For example, they can make an entry in the wing observation book, in the prisoner's file, they can speak to them personally or, in matters concerning health, they can refer the issue to healthcare. We know that the second prisoner said he told the first officer of his concerns about the man and that the officer spoke to him as she too noticed a change in the man's behaviour.

148. The reviewer said in her report that wing staff saw the man every day. She said there are procedures in place if anyone has a concern for a prisoner, and staff have immediate access to the In-Reach team. If the In-Reach team had been significantly concerned about the man, discussions would have taken place between them and Sevenacres for him to be transferred back.

149. She went on to say that it is standard practice for information to be relayed to wing staff regarding a prisoner's mental health history, and any treatment plans. The reviewer added that the man did not tell anyone of his intentions to harm himself.

What observations are used within the prison? What observations were in place for the man at the time of his death, and were these observations appropriate?

150. The reviewer said in her report that there was nothing in the man's Care Plan to suggest he needed any routine or frequent checking for suicide risk. The Prison Service has an ACCT (Assessment, Care in Custody and Treatment) document, which can be opened by any member of staff if they are concerned for a prisoner. She confirmed that the man was not being monitored under these arrangements, and that routine procedures were followed.

What resuscitation equipment is readily available within the prison and was it accessible at the time of the man's death?

151. In her report, the reviewer said there is a resuscitation bag available, which is kept in the clinic. Since the man's death the procedures have been looked at and improvements have been made to the contents of the resuscitation bag. The reviewer said that the changes would not have made a difference in the man's case.

152. The reviewer confirmed that CPR was commenced immediately. She added that it was two and a half minutes before the resuscitation equipment arrived and eight and a half minutes before a defibrillator was requested. The reviewer added that the ambulance arrived promptly, and that staff have been reminded of the need to respond appropriately and in a timely way with the relevant equipment.

What Mental Health Services are commissioned for prisoners? At the time of the man's death was he receiving the service commissioned?

153. The Prison Healthcare Commissioning Lead told the review meeting that there are two Service Level Agreements in place. One is with Hampshire Partnership Trust, which provides five sessions a week and a Consultant (The forensic psychiatrist), and the other is with the Mental Health Services on the IOW who provide the prison In-Reach Service.

154. The Commissioning Lead said the prison In-Reach is not a large team, and is currently made up of a team leader and four community psychiatric nurses who cover the three island prisons. She added that the service is not currently commissioned to provide extensive follow–up, but said there will be more funding to expand the team in time. The Commissioning Lead said the man was receiving the service in prison that had been commissioned from the In-Reach team and had been supported appropriately.

General discussion

155. As part of the general discussion about the man's medical care, the review panel also considered whether the system in place at the time had let him down in any way. The panel discussed documentation and agreed that medical records do not follow prisoners back to prison from Sevenacres. It was decided that, in future, Sevenacres would copy the discharge planning documentation and send it along with a discharge summary letter. It was thought that this would give prison staff a management plan of the prisoner's needs.

156. The panel highlighted that there was a delay sending the discharge letter and said it should have been sent on the day the man was transferred. It was acknowledged that there was an unacceptable delay in the man's case, although said it would not have made a difference to the outcome for him.

157. A prison doctor said that there are occasionally problems gaining access to medical notes and obtaining patients' past medical history. The reviewer said in her report that there is some work currently being undertaken to have an electronic system available compatible with the prison system. It would appear from the meeting that discussions have taken place in the past with a view to improving the current system.

158. It is clear from the report that a long term solution is being sought. However, in the meantime a solution should be found to ensure patient notes are not unduly delayed.

The IOW PCT should examine the difficulty of patient notes not being available to a prison doctor and find a solution.

GUM tests and results

159. The consultant psychiatrist suggested that the man might have received a positive result from the GUM clinic but not been provided with support. She asked whether a letter giving a positive test result might have gone to the man without the knowledge of prison staff, and therefore the man could have received bad news without the proper support.

160. My investigator discussed the issue of GUM test results with the clinical reviewer and asked him what the process was for accessing the clinic and how test results would be given to the prisoner. The clinical reviewer said prisoners have the same access to the clinic as any patient in the community. He said a prisoner can be referred by a doctor and, as the referring body, the results would be returned to the doctor. Alternatively, prisoners can refer themselves to the clinic, in which case the results are then given directly to them and are not shared with anyone else, including the doctor, unless the prisoner agrees to do so.

161. The clinical reviewer went on to say that the GUM clinic is operated by the Sexual Health Service (SHS). Whenever a prisoner makes a self referral, they deliver negative test results to the prisoner in a sealed envelope which is placed in the internal mail system. He said this prevents it from being read by any member of staff. The doctor added that positive test results are given to the prisoner personally by a member of the SHS and not shared without the prisoner's consent.

CONCLUSION

162. The man was well known to the IOW PCT Mental Health Service. He had been treated for a number of years by a variety of professional mental health staff and was given appropriate medication to stabilise his condition. However, as my report shows, the man decided to stop taking the medication and, although he was expected to become "hyper", he in fact appeared settled. I am satisfied from reading the clinical reviewer's and the reviewer's reports that the man's medical care was equal to, if not better than, that he would have received in the community.

163. The man has been described by those who had known him on a previous prison sentence as being a nuisance, and someone to be avoided at all costs. It was evident to them that he had changed when they next saw him, and that he appeared to be acting in a much more agreeable manner. It is often said at suicide prevention training events that once someone has decided to end their life they become more at ease with themselves, because they are in control of their own destiny and know what it is they are going to do. I am not sure that in the community anyone would normally know this, or suspect anything. However, my report shows that one officer had the presence of mind to talk to the man and asked him directly why he had changed and whether he was feeling suicidal. He said he was not.

164. In the absence of any final note to his family or friends, we do not know if the reason for the man behaving differently was because he had made a decision to end his life and, if so, how long he had been making his plans. What we do know is that he was regarded as being impulsive, which may explain his actions. However, I am satisfied that the man gave no indication to anyone about what he was to do on 14 April. Had he done so, I am equally satisfied that the support mechanisms were there for him.

165. Nevertheless, I am concerned at the length of time it took to discover that the man had harmed himself. My report shows that he was not found at the earliest opportunity. This is regrettable, and will be very disturbing for his family and friends. Whether the officer opening the cell door at lunchtime could have done anything to save the man is uncertain, but I do believe that he was the one who should have found him.

166. That aside, I am satisfied at the overall care shown to the man by the prison and Mental Health Service. I am pleased to be able to report good practice and have already described above how one officer decided to sit down and talk to him. I pay particular thanks to the officer who checked the man for himself. His positive action meant that he was the one who found the man hanging.

RECOMMENDATIONS

For the Governor

1. The Governor should consider how best to ensure healthcare staff know immediately what type of incident it is they are being asked to attend.

   The Prison Service has accepted the recommendation.

2. The Governor in partnership with the PCT should ensure that whenever urgent medical assistance is required, the emergency grab bag is taken to the patient immediately.

   The Prison Service has accepted the recommendation.

3. The Governor should remind all staff of the correct procedure for unlocking and opening a cell door.

   The Prison Service has accepted the recommendation.

For Isle of Wight Primary Care Trust

1. The IOW PCT should examine the difficulty of patient notes not being available to a prison doctor and find a solution.

GOOD PRACTICE

1. The fourth officer decision to check on the man's welfare was good practice.

2. The actions of prison management in reviewing all those on ACCT following the man's death were good practice.

3. The Governor's action in supporting her staff by arranging a Critical Incident De-Brief was good practice.