The circumstances surrounding the death of a prisoner at HMP Gloucester in April 2005

Report by the Prisons and Probation Ombudsman for England and Wales

February 2006

This is the report of an investigation into the circumstances surrounding the death of a prisoner at HMP Gloucester at the end of April 2005. He died by hanging. At the time of his death, the man was 37 years old.

My colleagues and I would like to extend our condolences to the man's family and to all those touched by his death. His family has raised a number of specific points in relation to his drug use, mental health and transfer from HMP Blakenhurst to HMP Gloucester. I hope this investigation goes some way to answering their questions.

Two of my colleagues, carried out the investigation on my behalf. One of my family liaison officers, visited the man's family and remained in contact with them. A clinical review of his health care and treatment at Gloucester was conducted by a doctor on behalf of West Gloucester Primary Care Trust (PCT). His review is annexed to this report.

I would like to thank the Governor of HMP Gloucester and his staff for their ready co-operation and assistance with this investigation.

The man's death was one of four apparently self inflicted deaths to have occurred in Gloucester during 2005. However, my investigators did not discern common factors with these other tragedies.

This report makes a number of recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman **February 2006**

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Summary

The man was initially remanded to HMP Blakenhurst on 4 April 2005, after spending four days in police custody. Having been given medication for heroin withdrawal during this time, he declined to undertake a detoxification regime upon his arrival at Blakenhurst.

On 12 April, he was transferred to HMP Gloucester on security grounds. These related to events that had occurred during a previous period in custody. Once at Gloucester, the man shared a cell with an old acquaintance.

The man was taken from Gloucester prison on a police production order to Rugby Police Station on 26 April. During the return car journey to Gloucester, he attempted to escape but was unsuccessful. Evidence suggests that this was a planned attempt which the man had believed would succeed. However, its failure led to him being placed on the escape list and thereby being subject to the E list regime. This included being located in a single cell, wearing distinctive clothing, and being checked once an hour when locked in his cell.

During the morning prior to the man's death, his ex cell mate found him to be upset and he spent some time talking with him. His ex cell mate thought that, by the time he left the man, his mood had lifted. However, that evening, whilst locked up for the night, the man passed a note to his ex cell mate that indicated his intention to end his life.

The man's ex cell mate, and his cell mate, rang their cell bell several times and asked to be able to go to see him. An officer responded but what happened next remains uncertain. Both prisoners have said that they were explicit in stating their concerns about the man's intention to take his own life and their need to see him. The officer refutes this and says they gave no reason for wanting to see the man. However, he did check on the man and his demeanour gave him no cause for concern.

At 1:10 am, whilst doing an hourly check, the OSG found the man hanging. The alarm was raised and staff attended immediately. Resuscitation was attempted, but sadly was unsuccessful. He was declared dead at 2:30am. The post mortem indicated that the cause of death was hanging consistent with a ligature tightened during life. No illicit drugs or alcohol were found in the man's body.

My investigators have been unable to determine the exact events that took place during the evening prior to the man's death. Differing accounts are given by two prisoners and two members of staff. Nonetheless, my report makes recommendations in relation to the need to document and record security decisions made about a prisoner's transfer to a different establishment, and in the day to day files and paperwork held about prisoners.

I also propose that procedures in relation to prisoners being placed on the escape list are reviewed so that issues concerning the risk of self harm and suicide are considered as part of the risk assessment.

Investigation Process

Two of my colleagues conducted a preliminary visit to HMP Gloucester on 3 May 2005, and returned on three subsequent occasions. During the course of initial inquiries, the investigation team were shown around the prison and visited the cell where the man died. They reviewed all the relevant documentation and established a chronology of events.

Notices were issued to staff and prisoners telling them of the investigation and offering them the opportunity to speak with my colleagues. A number of prisoners and staff were interviewed. A prison officer, an OSG and a prisoner were interviewed twice.

My investigators met with representatives of the local branch of the Prison Officers' Association (POA) and the Chair of the Independent Monitoring Board (IMB). No specific concerns were raised by either body.

The man's family were offered, and accepted, the opportunity to meet with one of my family liaison officers and an investigator. They raised a number of concerns relating to his possible drug use and the escape list regime. In addition, my investigators spoke with the man's probation officer and his legal representative.

The investigating team also visited HMP Leyhill to speak to a prisoner who had moved there from Gloucester. They also made enquiries at HMP Blakenhurst and spoke with a number of staff.

Background Information

HMP Gloucester

HMP Gloucester is a category B adult local prison and young offender remand centre, situated in the centre of the city. The prison is made up of three wings, each with three landings holding 90-100 prisoners.

The man who died was on A wing throughout his time at Gloucester. The cells for prisoners on the escape list (E list) are located on the two's landing (on the second floor) of A wing.

Events leading up to the man's death

Events up to the end of April 2005

On Friday 1 April, at 3:25 pm, the man was arrested under warrant at the family home and taken to a Police Station. According to the detention record, he told an officer that he was a heroin user and had smoked half a bag that day. He requested to see a doctor and at 7:08 pm he was seen by the Forensic Medical Examiner (FME). The FME report indicated that the man stated that he smoked 3-4 bags daily and had last used that morning. The FME prescribed a standard Dihydrocodeine and Diazepam regime. According to the form, the FME classed the man as 'no known risk' of self-harm. There is no medication form with the medical report, but the custody record indicates that he was given his medication at 7:10 pm that night and then four times the next day.

At 6:06 pm on 2 April, the man was taken to another Police Station for identification procedures in relation to another robbery offence and remained in custody there. On 3 April, he saw the FME at the Police Station at 11:50 am and complained of feeling cold due to the heroin withdrawal. He was further prescribed Dihydrocodeine and Diazepam. The FME recommended half hour checks, but did not record whether or not he viewed the man as a risk of self-harm. The medication form is attached and shows he was given medication at 9:00 am, 5:55 pm, and 10:00 pm that day. On the morning of the 4 April, he was given his medication before being taken to a Magistrates' Court at 8:15 am.

Following his court appearance, the man was remanded to HMP Blakenhurst, until 12 April 2005. His Prisoner Escort Record (PER), which had been completed at the Police Station on 1 April 2005, highlighted the man's risk area as 'drugs'. In another section about risk issues, it states 'DNA confirmed, firearms, escaper, drugs, offends on bail'.

Upon reception at Blakenhurst, a Cell Sharing Risk Assessment form was completed. This form is used to assess if the prisoner is a risk to themselves or others. Using the man's warrant and Prisoner Escort Record (PER) for information, Section 2 of the form notes that he had previous convictions for firearms offences. When asked about his use of alcohol and drugs, the man said he had neither abused or was dependent on either. He also said he had not been subject to any self-harm observational procedures (F2052SH) and did not have any concerns about sharing a cell. The officer notes 'previously been in BTBM [Blakenhurst] before, no problems'.

As part of the reception process, prisoners who request help for their drug abuse are required to take a urine test to establish that they are drug users and therefore eligible for the detoxification programme. The officer, who was working in reception that day, recognised the man as he had been at school with the man's brother. They chatted for a while about school days and the officer observed that the man seemed 'annoyed at having been caught'. He then asked, 'I think I know what the answer is, but do you do drugs? (meaning

do you need to have your urine tested?)', the man replied no. The officer then completed the Reception Clinical Urine Drug Test proforma writing, 'States does not take drugs'.

The man was then seen by a nurse who carried out a First Reception Health Screen. It was noted that he was on remand, had been in Blakenhurst before, had no health concerns and was not taking any medication. When asked about his drug use, he said he used heroin and cannabis daily and had last used on 31 March 2005. He was then asked about his mental health and reported no concerns. The man was referred to the drugs service (CARATs) and to see the doctor.

He was later seen by the doctor who noted 'states he would like to try to de-tox without medication. But has requested that if this proves too hard to start a Cofexadine detox.'(sic). The man was located on Houseblock 6 and completed his induction on 9 April 2005. His regime review on that date remarked 'compliant and polite, no problems'.

On 12 April, he appeared at the Crown Court charged with robbery and possession of a firearm. His PER, completed by staff at Blakenhurst indicated that he had 'no known risks', despite the information which had been previously given to Blakenhurst on the PER by the police. The man was further remanded and returned to Blakenhurst.

On Wednesday 13 April, an officer in the security department received a request from the Governor to arrange a transfer for the man from Blakenhurst to HMP Gloucester on security grounds. In interview, the officer confirmed that he was aware that the man had been moved to Gloucester before on security grounds. Information supplied on the inter-prison transfer document reads:

"Resides in the same street as … [members of staff] – one of which is his next door neighbour. History of conflict and he has slashed her car tyres. The man cannot be located on Houseblocks 1 and 3 as there are inmates against which and their families he has made threats to kill" (sic).

The officer phoned the Observation, Categorisation and Allocation (OCA) department of Gloucester. He spoke to an officer over there, explaining the situation and the officer at the OCA department said he would look into the matter. On Monday 18 April, the Governor asked if the transfer had been agreed. The officer from Blakenhurst had not by this time had a response from Gloucester. He phoned the OCA department there again. On this occasion he spoke to a senior officer in the security department who agreed the move.

At this juncture it is necessary to understand the nature of these security concerns. The man had been in Blakenhurst on a number of previous occasions. In 2003, officers on his wing reported that he was making threats against an officer. It seemed that the man lived in the same area as the officer and at one point it was believed he was responsible for writing her

address on the wall of the houseblock. Security reports were submitted at the time, even though there was no proof he was responsible. The officer also said the man made direct threats to her about damaging her car, and again security reports were raised in relation to this.

The officer's car was damaged after the man had been released and she believed he was responsible as he had seen her at a local garage. All four of her tyres had been slashed and she reported it to the Police. On another occasion, she said the man passed by her house as she was cleaning her car and she then realised that he lived just a few doors away from her. She contacted the Police for a second time as she said he was making threats to her and her family. She was advised to use extra security and was given a mobile phone to contact the police should something happen.

A few weeks later, the officer discovered that her daughter's car had been damaged. She said she felt the threat was becoming more serious and decided to sell her house and move, which she eventually did in August 2004.

During this time, the officer said she had spoken to her Senior Officer at Blakenhurst and eventually the man, by now back in custody, was transferred out. She expressed great shock when he arrived back there in April 2005 and again had to request his transfer because of their history. My investigators visited Blakenhurst but, although the security manager confirmed these incidents, there were no reports available.

On 18 April 2005, the man was transferred from Blakenhurst to Gloucester. A Security Information Report (SIR) submitted by one of the escorting officers indicated that he was very angry during the journey. According to the report, he did not want to be moved and blamed the officer from Blakenhurst for his transfer each time he arrived at Blakenhurst. He said he had been blamed for vandalising her car and made threats about what he would do when he saw her next. The PER completed on 18 April at Blakenhurst again indicated no areas of concern, with none of the risk sections highlighted.

Upon arrival at Gloucester, the man went through the reception process. His Cell Sharing Risk Assessment (CSRA) indicated firearms as a risk area. On this occasion, when he was asked about his alcohol and drug use he reported that he had abused both in the past but was not currently addicted. A nurse completed the Health Check paperwork and observed 'states fit and well. Declined MO [medical officer].'

He was located on A wing and began his induction the next day, 19 April. The programmes were completed on the same day. This was quicker than usual, but a note explains that he had been at Gloucester in August the previous year and was therefore familiar with the prison processes and procedure.

There is only one entry in his's wing history sheet whilst at Gloucester and that is 'standard', which related to his level of privileges on 23 April. The man seemed to settle well on the wing and nothing of significance came to the attention of the officers during this time. In interviews with staff, he was

described by officers as ‘mild mannered, polite, not a management problem etc’. According to the officer in charge of the cleaners, the man had asked about getting a job and had put his name on the waiting list.

It appears that the man and an old acquaintance bumped into each other during induction and agreed that they would like to share a cell together. In interview, the man’s acquaintance explained they had served sentences at similar times in other prisons and also were in contact in the community. They were located in a double cell (cell 24) on the second landing (the twos) of A wing. His acquaintance said that they talked a lot and the man had been concerned about the number of charges he was facing and the sentence that could result from them.

On 19 April, the Police faxed Gloucester a request for a police production order for 26 April. They requested that the man be collected by police officers and taken to the Police Station for the making of an identification video. The police liaison officer recommended and signed the form on 20 April and the Governor gave signed authority on 22 April. The prison received a second fax from the police on 21 April: the Prisoner Production Risk Assessment form. The form identified the man as a risk due to ‘firearms, escaper, drugs’. The prison had to complete its own security form, the Police Productions Security form, and under the security section a senior officer has written ‘no issues at this prison’. The form is dated 26 April. The man has one entry on his own security record from 22 April: it says information had been received from a prisoner that he and his cell mate were expecting to receive heroin in a greetings card.

According to his cell mate, the man was planning an escape. He was aware that the police were wanting to question him further and would therefore be taken out on a police production order. It was during this trip that the man was allegedly planning to escape. The man’s cell mate explained that the man had sharpened down a plastic prison knife and hidden it in his cell. He also said that the man, with his help, rehearsed certain scenarios: going through what was likely to happen and how he was going to effect his escape. According to his cell mate, the man was expecting the police to take him out for further questioning on Thursday 27 April, but they turned up on Wednesday 26 April. His cell mate said he saw the man briefly before he left, when he went into the cell to retrieve his hidden knife and to get some tobacco. The security senior officer, explained to my investigators that during random monitoring of the phone calls they had heard his cell mate talking about planning an escape. A security incident report was generated and the cell, which he was sharing with the man who died, was searched on 21 April. Nothing was found. They realised later that he been talking about the man who died and not himself.

In preparation for going out on the police production order on 26 April, the man was taken to reception. The senior officer on duty that day in reception, was responsible for preparing the man for discharge into police custody. The man was given a full search including undergoing a full strip search, which involves the prisoner taking off the top half of his clothes, which are searched,

putting these back on and then removing the bottom half. His mouth would also have been examined. All this would have taken place in the presence of two officers. At this juncture, it is worth noting that the officer was not aware that the man was deemed an escape risk. But in the interview he stated that, even if he had been, the search would have been the same. The PER form which would have been prepared by the prison the day before does indicate that the man was an escape risk. However, it is clear that this information was completed by someone other than the original author. My investigators have been unable to ascertain when and who added this piece of information.

At 9:05 am, he was released into the custody of three police officers from the Police Station.

He arrived at the Police Station at 11:10 am. He was met there by an agent for his solicitor, who described the man as relaxed and in high spirits. During the course of the day, a video was made of the man for use in an identification parade. According to the agent for his solicitor, the man was unperturbed by the process and was confident that he would not face any charges in relation to the offences. The purpose of the day had been to make the video and he was not charged with any offence. The agent from his solicitors said he was in the man's presence for the whole time until he left the station, at which point he was being booked out to return to prison.

The PER form does not indicate what time the police left the station with the man who died. The same senior officer was still on duty when they arrived back at the reception gate at Gloucester at 3:25 pm. The senior officer stated in the interview that, as soon as he 'got out of the car it was very relevant to me that the man had been involved in a confrontation of some sort, it was obvious that he had, for want of a better word, had been in a fight, that something had taken place with him because he was in an agitated state. He immediately was complaining to me that the police had beaten him up.' However, according to the senior officer, the police did not give any account of what had happened. It was not until they had actually left the reception area that the police officers then returned and said that they needed to let the prison know what had happened. The senior officer found this very strange and asked them to complete the PER form to reflect what had happened during the journey back to the prison. The police officer wrote in the PER that:

"Whilst travelling along M5 motorway the man produced plastic knife (burnt handle) moved forwards placing hands (handcuffed) round front nearside passenger's neck shouting 'I've got a knife, I've got a knife, I've got a knife at his throat.' Had to be forcefully restrained resulting in minor injuries to his wrists. Immediately apologised, knife seized. Was searched on arrival at police station and knife not found. The knife was handed to prison staff."

The senior officer described the knife as the blade part of a prison plastic knife, three to four inches long, which had been sharpened down to a point. The man told the senior officer that he had found it in the footwell of the car. A senior officer from the security department attended reception and spoke with the man. He said that he had found the knife under the seat in the police

car and that he picked it up on impulse. According to the senior officer from security, the man told a number of different stories to different people, but it was the senior officer's view that the knife appeared to be from the prison and it had been sharpened. According to one story he heard, the man had said that he had had it in his training shoe when he went out in the morning. The senior officer said he only saw the man briefly, but that he had his head in his hands and appeared regretful of what he had done.

A principal officer and the Police Liaison Officer went to reception to see the man. The PO described him as 'quite hyped up'. A decision was made with the duty manager to place him on the escape list. This meant that the man would be subject to a number of additional security restrictions. Primarily, he would be located into a single cell, would have to wear special clothing so that everyone would know he was an escape risk, and he would be checked hourly. Additionally, all in-cell possessions would have to be authorised by prison management on the advice of the security department. His case would be reviewed at the following monthly review meeting. The principal officer informed the man about the escape list regime and expectations which he appeared to accept without question.

In reception the man was also seen by a nurse and a F213 form (report of injury to prisoner) was completed detailing the extent of his injuries. The injuries were described as 'bruising back of hand, wrist abrasions, thumb injury'. The prescription chart indicated he was given a dose of Brufen. He was also referred to the see the doctor the next day.

An officer collected the man from reception and escorted him back to the wing. By this time he had already changed into the E list clothes (known as 'patches') and signed the form outlining the process. The officer knew the man from the wing, as well as his ex cell mate. The man asked for a shower, which was granted, and an officer accompanied the man and his ex cell mate to the shower. Whilst there, the officer recalls the man chatting about general things and his family. He was taken back to the wing, collected his meal and the officer recalls sitting with him in his cell for about 20 minutes. The man's ex cell mate was also present for some time. As part of the E list conditions, the man would not have been allowed to keep any cutlery in his room and the officer removed these when he left. He recalled that the man thanked him when he left and made a comment that he was going to be nailed for twenty years and had one chance and missed it. The officer said he got the impression that the man had thought his escape attempt was going to be successful and was disappointed when he had not succeeded. However, the officer did not think that there was anything worrying about the man's demeanour and was very shocked when he heard about his death.

In interview, a senior officer, who had no previous knowledge of the man, remembered him coming back in 'patches'. He gave permission for him to have a shower. He recalled sitting with the man in his cell and going through the E list procedures. He said the man said that he supposed he 'would not get anything, that he had really done it now and that the prison would be right

on top of him'. The senior officer tried to reassure him and explained that they would give him as much leeway as possible. He felt that the man was fine.

An officer who had chatted with the man previously, also spoke to him whilst he was being located into the escape list cell. Seeing him in the escape strip clothing, the officer asked what had happened and the man said that he had been beaten him up whilst in the police cells. He described him as being flustered at what had happened and 'focused' but did not give him any cause for concern.

The officer, who had no previous knowledge of the man, signed the E book between 7:30 – 8:55 pm. He took his trainers and clothes from him and said he seemed fine. An OSG took over from 8:55 pm until 8.00 am the following morning and checked on him throughout the night. The man gave him no cause for concern.

The day and early evening of 27 April 2005

A Senior Officer from C wing was helping out on A wing on 27 April. He explained that he recognised the man as someone he had known from a previous establishment. He said the man was wearing E list clothing. The man recognised him and they spoke for a while. He said the man appeared fine. He had asked him how he was in light of the E list clothing and because it was his practice to check that new prisoners were settling in alright. The man said that he was fine.

Another prisoner had been in Gloucester a few weeks and had been located in the cell next door to the man and his cell mate. On the morning of 27 April, following the man's move to the escape list cell, the new prisoner started to share the cell with the man's ex cell mate. He did not know his new cell mate, although he was friendly with the man who died. He said that when the man came back into Gloucester in the 'banana suit' everyone had a laugh, but that the man seemed to take this well. He said he saw the man who died on 27 April, but was not sure if it was on the exercise yard or on the wing. He said, 'he seemed the same, although he thought he had been upset about his girlfriend'. According to the Coroner's officer, a letter from his partner was found in the man's cell following his death. The letter appears to have indicated that she was ending their relationship and the postmark suggests it would have been given to him that day.

The man's ex cell mate said he saw him about 11:10 am on 27 April and described him as tearful. The man's ex cell mate was on his way back from education and the man who died was locked in his cell. He said he went and spoke to a senior officer as he was a bit concerned about him. The senior officer agreed for an officer to open up the man's cell and allowed him in to speak with him. The man's ex cell mate said he and the man who died were together for about an hour speaking about his worries about the escape and the sentence he thought he might receive for that offence, and the other charges he faced. He was worried that he would receive another long sentence and would be separated from his children. The man's ex cell mate

told him to pull himself together and said he appeared to perk up and they went down to collect their lunch together about 11:40 am. They returned with their lunches and again talked in his cell. The man's ex cell mate said that, when he finally came out of the man's cell, an officer asked him how the man was and he replied that he was okay. He also told the senior officer that the man was alright.

An officer collected the man from his cell and took him to see the doctor and then back to the wing. He did not have previous knowledge of the man. He was seen by a GP covering shifts at the prison, some time between 1:35 pm and 2:00 pm as a result of the injuries he had sustained the day before. (It is standard process to be referred to the GP within 24 hours.) The doctor felt he presented as a little bit disappointed, a bit down in the mouth. He was sore from the wrist and head injuries, but nothing very serious and the doctor advised him to come back in a week if they were not healing properly. According to the doctor, there was nothing worrying about the man's demeanour and he did not give concern about self-harm.

The man's ex cell mate saw him again later at about 4:30 pm and asked him if he was okay. He gave him some shaving foam and the man said he was alright.

The regime at Gloucester means that only one landing per evening has association. It was not the turn of the two's landing which meant that neither the man who died nor his ex cell mate were on association. The ex cell mate explained that at about 7:00 pm the landing cleaner came to his cell door and slid a folded piece of paper under it. He described it as folded like an envelope and he immediately noticed it contained tobacco. He said he knew it was from the man who died because no one else would be sending him tobacco. He opened up the envelope and it contained a note from him and some tobacco. The ex cell mate said it was a very down letter and described it as 'basically a suicide note'. In it the man had asked him to look after his partner and to keep the note confidential. He said in interview that he did not initially know what to do. The man had asked him not to tell anyone and he spent 15 minutes thinking about it. He spoke with his cell mate who persuaded him to ring the cell bell and to tell an officer. By now the time was about 7:15 pm and an officer answered the bell. What happened next is unclear as the accounts given by those interviewed differ. According to the man's ex cell mate, he said that his friend was 'not right' and that he 'was feeling a bit down' and that he needed to go over and speak to his mate. According to him, the officer said he could not come out of the cell.

The ex cell mate rang his cell bell for the second time and, when the officer attended again, he explained that a senior officer had said the he could go over and speak to the man. According to the man's ex cell mate, he explained that he had 'got a suicide note' and that the man would not speak to a Listener but he would talk to him. According to the ex cell mate, the officer then asked what cell he was in and he told him. He said the officer then left and he assumed he was going to check on the man. Looking through the gap in the door, he said that the officer did not check on him. Another officer, who

had no previous knowledge of the man who died, checked on him at around 8:30 pm, she was monitoring him as he was on the E list. She did not speak with him as there was no requirement to do so.

The man's ex cell mate then said that he rang his buzzer again and started to bang and kick the door. The glass panel in the door cracked and he was expecting to be placed on a disciplinary report the next morning. He described himself as 'very hostile and aggressive' at this point. He estimated the time now to be about 8:55 pm. At this point, another officer was locking up the prisoners who had been on association that night and the man's ex cell mate said he was ignored.

He then said he waited until 9 pm when the night officer came on duty. According to the ex cell mate, when the night officer came round doing the roll check, the ex cell mate spoke to him, told him he was a bit worried about his friend and the night officer agreed to check on him. The ex cell mate said, on each occasion the night officer passed his cell, he asked how the man was and the night officer replied he was fine, he did this a few times during the night. At about midnight, he said that he was still awake. By standing on a chair in his cell he could see the door to the man's cell at an angle and noticed that the light was on. He said that the man did not like light and so he was worried about this. He said he again spoke to the night officer and asked him to check on the man. The night officer did so, and reported back that the man was making toast (by removing the mattress from the bed and putting the toast on the wire frame and burning it from underneath). The ex cell mate said he checked and saw that the man's light was now off. He got undressed and into bed himself at about 12:30 am.

In his interview, the night officer explained that he was checking the man regularly not because his ex cell mate had alerted him, but because of the E list procedures. In fact, the night officer was adamant that he did not have any conversation with the man's ex cell mate or his cell mate regarding the man who died.

The other cell mate said a note came under the cell door at association time. He said he and the man's ex cell mate got on the buzzer and shouted at the officer something like 'he's going to kill himself, get him in a strip cell' or 'get a watch, he's doing himself in'. He said they passed the note out to the officer under the door or through the gap in the side. He said the officer looked at it for five or six seconds and returned it saying, 'get your heads down'. According to the other cell mate, the officer did not go and check on the man. He said the man's ex cell mate kept ringing the cell bell, but it was turned off. He described how the officer, whom he did not know, was standing a few doors down from their cell and they shouted at him, 'he does what he says', meaning the man would go through with it. However, the other cell mate said the officer did not react.

Later, he said he and the man's ex cell mate talked to the night officer who was more helpful and they asked him to keep an eye on the man. He said they went to bed about 12:30am.

The officer's account of the evening differs somewhat from the versions given by the man's ex cell mate and his cell mate. He agrees that the man's ex cell mate rang his cell bell several times that evening. In interview, he said that both the prisoners in the cell asked to be let out to use the toilet and the officer decided to let one prisoner out to use the toilet on the wing and suggested the other used the facilities in the cell. The second time the cell bell was rung, he said they asked him to go over to the man's cell and check on him. When he did this, he said the man was lying on his bed watching TV. He explained that he went back over to the man's ex cell mate's cell and let them know that the man was okay. The escape list log for that evening shows that the officer signed it for the hours 5:30 to 6:30pm and again 7:30 to 8:30pm, thus indicating that he had checked on the man in his cell twice that evening.

The officer said the man's ex cell mate then wanted to go across to the man himself and he had told him this was not allowed. In interview, he remembered that the ex cell mate had repeatedly asked, stating that one of the SOs who had been on duty earlier that day had agreed to it. The officer then went and spoke to the SO who was in charge of the wing that night to check the position. The SO had confirmed what the officer thought.

The officer said that, at this point, the ex cell mate lost his temper and they exchanged words. However, he said he did check on the man a couple of times that evening. On the last occasion, just before he went off duty at 9pm, he spoke to the man asking him if he was all right and the man said he was. In the interview, the officer was asked if he had been shown a suicide note or if either of the two other prisoners involved had said that the man was suicidal. The officer was unequivocal and said that neither had happened. The officer said, 'he just said that he wanted to go over and he didn't give me no reason why he wanted to go over there'. He was confident that he would have acted in quite another way if they had. The officer did not make any entry in the Wing Observation Book about his discussions with the two prisoners.

Another prisoner in a nearby cell, also saw the man on 27 April in the exercise yard. He said they spoke briefly and he described the man as 'walking around like a zombie, you could see he wasn't right, he wasn't the person he came in as'. Later that evening, the other prisoner heard the man's ex cell mate 'shouting a lot and banging the door of his cell'. He said the officer was responding to the cell bell and he and others asked him to keep the noise down. He said he then heard the man's ex cell mate shout 'let me out' and 'could someone go and speak to him'.

(During the course of this investigation, the team were given a copy of the note passed between the man who died and his ex cell mate.)

The night period of 27/28 April 2005

A night orderly officer was the Principal Officer in charge on the night of before the man died. He came on shift at 8:30 pm and was aware there was an 'E' man and that he was on hourly checks. An OSG came on duty about the same time and was in charge of A Wing that night. The night orderly officer checked with him that he knew that there was an E man and which cell he was in. The OSG confirmed that he did.

The OSG explained that during the night he was checking the man once every hour, as well as doing his 2052SH checks on other prisoners and other duties. He said he spoke to the man at about 11:20 pm as he was doing his rounds. He said that at this time the man was watching television and the OSG had asked if he was alright. He said the man replied, 'yes, I am fine boss'. OSG again checked the man at 12:20 am and said he appeared to be asleep on his bed.

At 1:20 am, the OSG checked on the man and found him hanging with a bedsheet from the window bars. He immediately radioed for help and spoke to the control room. At that time, two officers, another OSG and a nurse were involved in a serious self-harm incident on B2 landing when they heard the call over the radio. They all responded to the call. The two cells are very close together and staff only needed to travel 30 metres to get from one cell to the other.

One of the officers said he could also hear the OSG on duty shouting that the 'E man was hanging' as they made their way across the bridge that connected A and B wings. When they arrived, the OSG was opening the cell door with his key from his emergency pouch. He entered, followed by the two other officers and the nurse. By this time, a further officer had also arrived at the cell.

The OGS on duty at the time cut the ligature with his emergency pack scissors and the three officers lowered the man to the floor. The nurse said she immediately started cardiopulmonary resuscitation (CPR) and, under her instruction, the OSG assisted her by doing the compressions while another of the OSG's went downstairs to collect the defibrillator and emergency bag which was in the nursing station on the one's landing. She said she then instructed the Night Orderly Officer to call an ambulance and a doctor. When the OSG returned with the defibrillator, they put it on the man. However, the reading indicated that there were no signs of life and not to shock. She could not find a pulse, so continued with CPR assisted by the OSG. The nurse observed that the man's body was still warm and she had thought they might have been able to save him.

The Principal Officer explained that he cleared the scene to allow the others to work on the man. He then called the control room and asked for an ambulance; he thought it was about eight minutes before they arrived. The control room log shows the ambulance was requested at 1:23 am and arrived at the prison gate 1:27am and was on the wing at 1:30. At one point, the

Principal Officer said that he took over the chest compression from the OSG while he fetched a piece of equipment. Then the ambulance crew arrived. He said he sent one of the officer's back to his duties on B wing. As the Night Orderly Officer, he stayed in control of the scene, working over the radio issuing instructions through the control room.

The night incident log shows that a doctor was called to the prison at 2:10am. A Doctor is recorded as entering the prison at 2:20 am. He pronounced the man dead at 2:30am.

The contingency plans for a death in custody were then put into effect.

Contact with the family

Upon reception, the man had named his partner as his next of kin. At 5:15 am, the Governor contacted the Police and asked them to break the news to the family. He also requested that they stay with them while the family phoned the prison and spoke with the Governor.

There was some delay in contacting the man's partner as there was a problem with the phone number that the man had supplied. When the police later visited her home, she was not there. She eventually contacted the prison at 11 am, having just been told about the man's death by the police. The man's mother was then informed and she contacted the prison at noon.

The following day, the Governor, the deputy governor, the family liaison officer and the chaplain met with the man's partner, his mother and his brother. Members of the family were offered the opportunity to visit the cell but declined. However, they did ask for a prayer to be led by the chaplain and this was done.

The Governor issued notices to staff. He also arranged for a notice to be put into each cell on A wing to inform prisoners that the man had died during the night.

The family said they had no concerns about the way the prison had treated them. In fact, they found all the staff they met to have been sensitive to their situation.

At Gloucester police station, the family had been given the blanket the man had used as a ligature but not his personal effects. The man's partner and brother then went to the prison. They were seen immediately by the deputy governor. The Governor, who was not on duty at the time, came to the prison immediately.

I am pleased to commend the actions of the Governor and his colleagues.

Issues considered during the investigation

The man's drug use

The man who died found himself arrested after a significant period out of custody. His family had noticed a clear deterioration in him in the previous six months, and they were concerned that his mood was related to drug use.

It would seem that the man had a heroin problem that he sought to keep hidden from key people in his life: his family, his cellmate and his probation officer. At the police station on 4 April, he disclosed that he used heroin and asked for medication to deal with withdrawal. However, upon reception at HMP Blakenhurst, he denied using drugs. The officer to whom he was talking mentioned to the man that he recognised him and knew his brother. We cannot know whether this played any part in his decision not to undertake a urine test (thereby making him ineligible for detoxification, something he had gone through on at least one previous period on remand in Blakenhurst). Whether the man experienced any withdrawal symptoms is uncertain. He did not subsequently complain to the doctor or nursing team that he was suffering from withdrawal.

The transfer from Blakenhurst to Gloucester

It is clear that the man had a history at Blakenhurst and there were particular difficulties concerning one of the female officer's. While allegations are not the same thing as proven truth, Blakenhurst owes a duty of care to its staff. That said, there is no paper trail showing what decisions were taken regarding the man's original transfer and the reasons they were taken. Moreover, it appears as though the second transfer may have happened just because the officer suggested it. The man's current file showed no concerns of a risk against staff. Paradoxically, his paperwork described him as 'not a problem'.

Prison staff, like everyone else, should be able to go about their work without fear of intimidation or threat. I think it was right that, each time the man arrived at Blakenhurst, he was transferred out. However, a record of the decisions would have made it much easier to piece his story together.

The man's escape attempt

The man had an offence of 'escape from lawful custody' amongst his previous convictions. According to the senior officer in the security department, this might have been known by the security department at Gloucester when they drew up their risk assessment for his police production request. The senior officer completed the form and wrote, 'no issues at this prison'. The form is dated 26 April, although it is not clear who dated it as the form also had to go to two other departments in the prison before being completed.

As a result of random phone monitoring, the security department had suspected that the man's cell mate was planning an escape. On 21 April, the senior officer had conducted a search of their cell and found nothing. This is

the same day the prison received the risk assessment form from the police stating that the man was an 'escaper'. It would have been prudent for the SO completing the police production security form to have informed the police about the current information about his cell mate. This might have led the police to treat the man differently.

His family were clear that the imposition of E list restrictions on him would have affected his mood. The man had been on the E list on a previous sentence, and his family described him as very down during that period which they attributed to the restrictions he was living under. He had been subject to closed visits previously, but this would most likely have been as a result of receiving drugs during a visit rather than being on the E list.

Each establishment operates the E list guidelines according to what is appropriate to that prison. The man's previous experience of the E list was at Whitemoor, a high security establishment. It is possible that the E list procedures there were implemented differently. This may have been difficult for him to deal with, particularly as his family believe he was subject to them for about seven months. However, at Gloucester the E list restrictions were not unduly restrictive and wing staff had sought to reassure the man that he would be fairly treated.

E list procedures

The guidelines for monitoring those on the E list stipulate that, 'The wing manager MUST IDENTIFY a member of staff on a daily basis to be responsible for observations and movements of the inmate and the updating of the F1352, designated cover for the member of staff's meal breaks must also be assigned'. At Gloucester, this was not done for the practical reason that no single officer remained on the wing for the duration of a shift. However, this did not have any impact on the supervision of the man and he was always monitored appropriately.

One of the rules for an E list prisoner is that 'no prisoner is allowed in the cell'. My investigators asked a number of officers, at all grades, how they interpreted this rule and varied answers were given. My investigators were led to believe that no in-cell association after lock-up would be allowed for any prisoner without prior arrangement. Having said that, it would seem that the man's ex cell mate had been allowed into his cell, albeit with an officer posted outside the door, when he had been distressed earlier in the day. This seems an entirely reasonable decision by the Senior Officer, given that he had been reported as upset.

The E list is, of course, primarily concerned with the risk of the prisoner escaping. However, it would be prudent to consider the placing of someone on the E list as a 'change in circumstances' and that the prisoner should be monitored accordingly - including an explicit consideration of welfare and risk of self-harm. All staff who saw the man who died felt that he was not at risk of self harm or suicide, and he presented as a very strong character. However, more specific questions such as why was he trying to escape, how did he feel

about being caught, how desperate he might have been to try, and then how he felt when he failed, might have uncovered different feelings.

Events during the evening before the man died

The accounts of the discussions between the officer on duty, the OSG and the two prisoners during the early evening of are conflicting. The two prisoners both say they were explicit about their concerns for the man and that they said he was suicidal. The officer is adamant that the prisoners did not say that the man was suicidal or that they had received a suicide note from him. If they had, the officer was clear that he would have acted differently. As far as he was concerned, the prisoners had just said he was upset and he thought this was because he was 'in patches'. As it was, he went to the man's cell to ask him if he was okay, and was reassured that he was. At 9 pm, the officer went off duty. The OSG is equally adamant that he did not have any involvement with the two prisoners regarding the man who died during that evening.

The exchanges with the officer took place in a very heated atmosphere and what was said may have been understood differently. In interview, the prisoners believed they were clear about their worries. However, while the officer clearly heard and understood that the man was thought to be upset and went to check on him, he interpreted the concern in a different way.

The senior officer said that, during a conversation with one of the prisoners the morning after the man was found, the prisoner blamed the officer on duty for not allowing him over to speak to the man the night before. The senior officer said he explained to the prisoner that this was not permitted and he agreed that this was the rule. However, in interview, the senior officer observed that he had relaxed the rules the day before, allowing the cell mate into the man's cell. He remarked that, at the time he thought this was important, as the man was reported to be feeling down. However, he recognised this might have set a precedent, leading the cell mate to believe he could go and see the man at any time despite the rules. The SO also acknowledged his action might have put the Officer in a difficult position in trying to work according to the rules.

Record Keeping

There are very limited entries in the man's core record, including his wing history sheet. Although some staff interacted with the man quite extensively, this was not reflected in the entries. Even when the man returned to the prison on 26 April and was placed on the escape list, this was not put in the wing observation book until the next day and was not written in his wing history sheet. There is only one entry in his wing history sheet during the duration of his time in Gloucester. The core records during his time at Blakenhurst are equally limited**.**

Simon's assault allegation

My investigators contacted the Independent Police Complaints Commission (IPCC) on a number of occasions in an attempt to establish the nature of their investigation into the man's assault allegation and his attempted escape. They have been unable to establish the outcome of these investigations or whether the police had intended to charge the man with an offence in relation to the attempted escape and assault on the police officer.

Conclusions

The man's drug use, and his decision to keep it a secret, may have meant that he did not seek help whilst in custody. Whether this impacted on his state of mind is unknown. Having planned an escape which he believed he could pull off, the man found himself back at Gloucester prison in escape 'patches'. Whilst the man was spoken to by several staff about being on the E list and the implications of this, he was not specifically asked questions in relation to his risk of self harm or suicide.

It seems likely that his failed escape attempt did affect the man's state of mind. We also know from conversations that he had with his cell mate that he felt concerned about the prospect of serving another long term prison sentence. The man may also have been upset on 27 April because of the letter from his partner questioning the future of their relationship.

With regard to the escape, a more thorough security intelligence check might have established a link with the cell mate's telephone calls apparently planning an escape. Passing on all the information might have led the police to handle the man's security requirements differently.

Blakenhurst were unable to provide any audit trail in relation to security information regarding the man's alleged threats to prison staff and his consequent transfer to a different prison. They also failed to record information provided on PER forms in relation to him being an escape risk.

The most contentious issue in this case concerns the conversations that allegedly took place between the officer on duty, the man's ex cell mate and his cell mate during the evening of 27 April and the conversations between the OSG and the same two cell mates, later on that evening. It is not clear to me or to my investigators what the true version of events is.

The Clinical Review found no omissions in the healthcare received by the man who died while in custody. The post mortem found that he died from strangulation, consistent with hanging.

The staff involved at the time of discovering the man's body did all they could to revive him. They are to be commended for their actions.

Recommendations, housekeeping points and good practice

Local recommendation 1: *The governor of Gloucester should consider reviewing the local E list guidelines with the aim of ensuring that specific consideration is given to a prisoner's risk of self harm or suicide after being placed on the escape list.*

Local recommendation 2: *I recommend that that the security department at Gloucester examine their methods for drawing together information in relation to risk assessments for a prisoner going on escort.*

Local recommendation 3: *I recommend that HMP Blakenhust review their systems for recording PER information and for handling security intelligence information.*

Housekeeping point a: *The governors of both Gloucester and Blakenhurst prison should remind their staff of the importance of detailed and regular written entries in all prison records, particularly wing history files.*

Housekeeping point b: *Staff should be reminded to write incident reports that contain as much detail as possible, as soon after the event as they are able to. The duty governor should also ask wing staff to write a statement if they had significant contact with the person who died in the day prior to their death.*

Good practice

The staff involved at the time of discovering the man's body are to be commended for their efforts in attempting to save his life.