

**The death in custody of a male prisoner  
at HM Prison Leicester in May 2004**

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

**April 2005**

This is the report of an investigation into the circumstances surrounding the death of a male prisoner at HM Prison Leicester on 15 May 2004. The prisoner was found hanging by his cell mate at about 10.25pm. He had been in prison for only three days.

The investigation was conducted under the terms of a transitional agreement between my office and the Prison Service, which took effect from 1 April 2004. In keeping with that agreement, a Prison Service Senior Investigating Officer (SIO), and his assistant carried out the bulk of the investigation on my behalf under the guidance of my colleague. I am grateful to them for their thorough investigation. I have structured this report so that the SIO's detailed investigation can be separately identified and read in full.

In addition, I commissioned an independent clinical review of the management of the prisoner's health needs while he was in custody at Leicester. This was carried out by representatives of the Eastern Leicester Primary Care Trust. I am most grateful to them for their work.

My thanks also go to the Governor and staff at Leicester prison for their co-operation during this investigation.

Like many of the deaths in custody I investigate, this is a sad story of a wasted life. However, I have found no reason to believe the prisoner's death was predictable or that the decisions taken about his care by HMP Leicester were unreasonable.

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman for England and Wales**

**April 2005**

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## **2. Summary**

The prisoner arrived at Leicester prison at about 7pm on Thursday 13 May 2004, after being remanded into custody by Chesterfield Magistrates. When he entered prison, he was mourning the loss of his long term partner who had died in February. He had increased his use of heroin since her death and carried her photograph with him.

A first reception health screen was completed by a nurse and the prisoner was seen later by a doctor in the First-Night centre of the prison. He was not considered to be suicidal by any of the medical or discipline staff who spoke with him that night. The prisoner was put into a shared cell. He had a change of cellmate after a short time, but was acquainted with the new person, as they had travelled together from Chesterfield Magistrates. The prisoner apparently had a very disturbed first night, ate two lots of food, took all of his tablets and was then very sick and sweaty during the night. An officer tried to talk to the prisoner the next morning but he said he was alright and that he did not have any problems.

A nurse from the Drug Harm Reduction Team spoke with the prisoner on the Friday morning and gave him a pack of medication that would give him symptomatic relief. She also checked that the prisoner would be receiving Lofexidene for his drug detoxification. The nurse remembered that the prisoner told her that he was grieving for his partner but that he was not suicidal.

A member of the CARATS (Counselling, Assessment, Referral, Advice and Throughcare) team also saw the prisoner on Friday. She asked him if he was suicidal because of the death of his partner. He told her that he would not consider doing anything because his partner would be watching him and that she would not want him to commit suicide. She would want him to prove to her that he could get himself off drugs and sort himself out. The prisoner also told the CARATS worker that the chaplain was putting him forward for a bereavement course.

On the Friday afternoon, the prisoner was moved to the detoxification landing and was allocated a new cell mate. The cells on this landing were in the process of being converted to safer cells. Safer cells are designed so as to make it very difficult to attach a ligature to the fittings and furniture in the cell. The prisoner was put into one of the only two cells that had not yet been converted. He had not given any indication to staff of being suicidal at this point, and I therefore do not consider the decision to put him into that cell as unreasonable. That night, the prisoner and his cellmate apparently sat up talking as neither of them could sleep because of their drug withdrawal.

On Saturday, the prisoner again appeared to be alright. He asked for some writing paper and subsequently wrote two letters. One indicated that he was finding drug withdrawal easy, and was making plans about where to live on release. He also asked his friend to come and visit him in prison the following Thursday. In the other letter, he thanked some people for looking after him

and said that he was in a bad way over the death of his partner. He went on to ask them to keep his clothes and photographs safe whilst he was in prison. That day, the prisoner took a period of exercise outdoors and spoke to a friend. He told his friend that he was upset about a conversation he had had with another prisoner about his partner's death.

The prisoner and his cellmate were locked in their cell at about 5:40pm. The cellmate was very tired and took his medication and then fell asleep at some time between 7.30 and 8pm. He awoke about two and a half hours later and found the prisoner hanging from the window bars by a bed sheet. He tried to undo the ligature but could not. He then alerted staff using the cell call system and by kicking the door. There was some dispute in the statements about the time it took staff to respond. The cellmate changed the account he gave to police and said there was a delay of around 20 minutes in staff answering his alarm and a further delay in them entering the cell. This is not borne out by the five staff statements or by the views of other prisoners who were in cells nearby. On balance, I do not think there was an undue delay in staff responding to the incident.

Attempts by staff and paramedics to revive the prisoner failed. The prisoner was pronounced dead by the prison doctor at 10:55pm.

The prisoner was depressed about his partner's death, but told several staff that he was coping and appeared to be doing so in the eyes of the staff and prisoners around him. He was asked on more than one occasion if he felt suicidal but told staff that he did not. The prisoner had no history of self harm or suicide attempts.

I do not think that the prisoner's death could have been predicted by the prison, nor do I criticise them for not subjecting him to suicide and self-harm monitoring procedures. However, I do agree with the opinion of the clinical review team that recent bereavement should be carefully weighed and considered by medical staff as a factor indicating that someone may be at risk of suicide.

I make one recommendation to the Prison Service, four to the Governor of Leicester and one to the Primary Care Trust.

### **3. Consideration of main findings**

Listed below are the key findings identified by the Senior Investigating Officer and by the Primary Care Trust alongside some comments of my own:

#### **Self harm risk factors**

- The prisoner had been deeply affected by his partner's death and was mourning her loss when he entered prison on 13 May 2004.
- He told staff that his partner's death had affected his mind and that he was using drugs as a coping mechanism.
- He had been ostracised by his partner's family after her death. The family had not allowed him to attend her funeral. They had blamed him for her death.
- He had been treated by his GP for depression.
- He bore with him a photograph of his partner.
- He admitted to staff that he had increased his drug usage after his partner's death. On arrival at Leicester prison on 13 May 2004, he looked unshaven and dishevelled. He demonstrated an incapacity to self-manage his prescribed drugs. He experienced poor sleep.
- He was upset on the day of his death following a conversation with another prisoner about the nature of his partner's death.
- The prisoner had no psychiatric or self-harm history prior to his arrival at Leicester on 13 May 2004. However, he was a heroin addict and was suffering from depression in the aftermath of his partner's death.
- His first reception health screen was completed properly, and he was seen by a doctor within appropriate timescales. On both occasions, he openly communicated to staff the fact that he was depressed about his partner's death and that he had been prescribed diazepam for his resultant depression. He was also frank about the fact that he was addicted to heroin and had been using drugs as a coping mechanism. The prisoner was seen the following day by a detox nurse and a CARATS worker. Neither assessed him as being at risk of suicide.
- I take seriously the helpful comments made in the clinical review about the numerous factors that might have led staff to consider the prisoner's likelihood of self-harm differently. But the prisoner consistently told staff that he was not suicidal. His responses were accepted and no self-harm monitoring procedures were invoked.

- I draw the conclusion that staff in the prison acted reasonably in this case but would ask the Prison Service to remind all staff, but in particular clinically qualified staff who carry out initial or subsequent assessments of prisoners, of the risk factors associated with suicide. Some of these risk factors are bereavement, substance misuse and depression.

### **Choice of cell and cell mate**

- The prisoner was located in one of only two cells in the detoxification unit that had not been modified as ligature-free. It is unfortunate that some cells had not been made ligature-free at the time of the prisoner's death. The fact that he was not allocated to a ligature-free cell would have been a significant factor in his ability to take his own life.

### **Speed of response to the alarm raised by the cellmate**

- The information given by the prisoner's cellmate to the investigation team differed from that which he gave to the police. The SIO interviewed the staff who responded to the cellmate's alarm and a number of prisoners who were in the vicinity of the incident scene. None of the prisoners who were interviewed thought that there had been an undue delay in the response given to the alarm. None of the staff who were interviewed received any complaint from the cellmate about there being an undue delay in their response.
- Given that the cellmate told the police that staff responded immediately to his alarm, I draw the conclusion that the version of events he described to the police is likely to be the correct version.

### **Detoxification**

- Although appropriate detoxification medication was issued to the prisoner within appropriate timescales, the Primary Care Trust draws attention to the fact that he was not given a urine test and that his blood pressure was not taken. The PCT also points out that the prisoner's detoxification regime was inappropriately signed as completed. These are important housekeeping points.

### **Record keeping**

- An entry made in the first reception health screen form states that the prisoner had told staff that he had been prescribed diazepam by his GP. This contrasts with a tick-box response made in the mental health section of the same form, which indicated that the prisoner had not been prescribed any psychiatric medication for his nerves.
- This is an example either of poor record keeping or of inconsistent interpretation of the questions asked in the health screen form. Neither is acceptable.

### **Leicester's Suicide Prevention Policy**

- Though Leicester's Suicide Prevention Policy document states that a representative of the prison's escort contractor should attend meetings of the Suicide Prevention Team, this does not happen as a matter of course.
- There is a well organised and active Listeners scheme available in the prison.

### **Care for the family**

- The prisoner's cell was cleaned and tidied for the visit by his family. Fresh flowers were also placed in the cell. This represents care and compassion for the bereaved and a mark of respect for the deceased. It is good practice that I am pleased to commend and draw to the attention of others.



## **4. Recommendations**

### **National recommendation 1**

Governors should remind medical and other staff to give due consideration to all of the risk factors that may make someone at risk of committing suicide. Recent bereavement, substance misuse and depression being some of these factors.

### **Local recommendation 1**

The Governor should arrange for all cells in the first night centre and detoxification landing to be made ligature-free, if this has not already been completed as part of the refurbishment programme.

### **Local recommendation 2**

The Governor should remind medical and nursing staff that detoxification procedures should incorporate urine tests and blood pressure tests.

### **Local recommendation 3**

The Governor should remind nursing staff of their responsibilities for good record keeping in accordance with the requirements of their professional bodies. Records and standards of record keeping should be locally audited on a regular basis in partnership with the Primary Care Trust and prompt action taken to rectify any deficiencies and training needs.

### **Local recommendation 4**

The Governor should ensure that meetings of the Suicide Prevention Team are attended by those staff and representatives listed in the prison's Suicide Prevention Policy document.

### **Local recommendation 5**

The Primary Care Trust in partnership with the Governor and Head of Healthcare should review the findings of the clinical review and ensure a time bound local action plan is developed to address its learning points. This should form part of the local Prison Health Development Plan.

**Stephen Shaw**

**Prisons and Probation Ombudsman for England and Wales**

**April 2005**

## **PART TWO**

### **SENIOR INVESTIGATING OFFICER'S REPORT**

#### **Introduction**

The prisoner was discovered hanging from his cell window by his cellmate, at approximately 2225 hrs on 15 May 2004. The cellmate awoke to find the prisoner hanging and raised the alarm. Staff attempted to resuscitate him but were unable to revive him. The prisoner was pronounced dead at 2255 hrs.

The Prisons and Probation Ombudsman commissioned this investigation.

The Senior Investigating Officer is from HMP Ashwell and the Investigating Officer is from HMP Wellingborough.

## **Terms of Reference**

### **NOTICE OF AN INVESTIGATION BY THE PRISONS AND PROBATION OMBUDSMAN**

Under my terms of reference from the Home Secretary, I am required to investigate and report on the circumstances of the death of a male prisoner on 15 May 2004 at HMP Leicester.

The objectives of the investigation are:

- To establish the circumstances and events surrounding the prisoner's death, including the care provided by the Prison Service, and relevant outside factors
- To examine any relevant health care issues and assess clinical care, in conjunction with the National Health Service
- To examine whether any change in operational methods, policy, practice or management arrangements would help prevent a similar death in future
- To ensure that the prisoner's family have the opportunity to raise any concerns they may have and that these are taken into account in the investigation and report
- To assist the coroner's inquest.

My report may include recommendations.

Evidence provided to the Ombudsman may be shared with specialist advisers and with other investigating bodies including the police, where that is necessary for the purposes of the Ombudsman's investigation, for the inquest or for a criminal investigation.

The report, and the evidence on which it relies, will normally be given to the Coroner, the Prison Service, the prisoner's next of kin and any other persons who the Coroner considers have a proper interest in the inquest.

## **TIMESCALE**

If you anticipate any difficulty in completing the investigation and report within timescales, please let me know as soon as possible.

**STEPHEN SHAW**  
**PRISONS AND PROBATION OMBUDSMAN**

**19 May 2004**

## **Investigation process**

The investigation began on 21 May 2004 at a meeting convened at HMP Leicester by an investigator from the Prisons and Probation Ombudsman's Office. The Investigating Officers, the Governor of HMP Leicester, Prison Officers' Association, and Independent Monitoring Board representatives, the Coroner's representative, and the Police attended the meeting.

On 21 May, the Investigating Officers were shown the scene of the incident and carried out a brief tour of the residential area.

On 26 May, the investigation team visited the prisoner's mother to offer their condolences and to inform her that the investigation had commenced.

On the same day, notices were issued inviting prisoners and staff to make themselves known if they wished to be seen by the investigating team.

The investigating team reviewed the documentary evidence and interviewed staff and prisoners at HMP Leicester, HMP Bedford and HMP & YOI Onley.

An independent clinical review of the management of the prisoner's health needs was undertaken by the Eastern Leicester Primary Care Trust.

## **The incident and events leading up to the death**

The prisoner was received into custody at HMP Leicester having been remanded into custody at Chesterfield Magistrates Court. He arrived at approximately 1900 hrs on Thursday 13 May 2004.

Part A of the PER form that accompanied him had "No Known Risk" ticked along with "Drug and Alcohol Issues". As there were other boxes ticked and then corrected with the author's initials and "Not" written beside them, he was contacted by telephone. The author had made mistakes on the form as it was the first time he had encountered the document.

He had ticked "No Known Risk" as the prisoner's attitude on arrest did not give him cause for concern. He explained that the prisoner had been cooperative whilst in custody and during his appearance in court. He mentioned the photograph the prisoner had in his possession when arrested, which was of his girlfriend who had died a few months earlier. When he asked the prisoner about the photograph he said he wanted to retain it as a memory of her and because he felt he had been blamed for her death and he had not been welcome at the funeral.

The prisoner had suffered the loss of his long term partner in February 2004. She died from a drug overdose. Prior to her death she had been in a car accident. Her injuries were minor and in no way contributed to her death, according to the Coroner.

On arrival at HMP Leicester, the prisoner was seen by a reception officer who completed a Cell Sharing Risk Assessment form and ticked the boxes for no open or previous F2052SH. The prisoner was then seen by a nurse who carried out the First Reception Health Screen. The nurse established that the prisoner had used heroin to the value of £50-£100 per day and that he was taking Diazepam prescribed by his GP. She also recorded that he was suffering from anxiety, depression and was excessively withdrawn. The nurse did not consider that he was suicidal.

The prisoner was then seen by a doctor in the First Night Centre. The doctor interviewed him and filled out a medical assessment form. She established that the prisoner was a heroin user and had been prescribed Diazepam, also that the Police Surgeon had prescribed Dihydrocodine to alleviate the symptom/heroin withdrawal. She ticked the box marked "no suicidal/self harm indication"; she assessed him as relaxed and calm. She explained the detox protocol and the group of medications he would receive that evening and that he would be seen by the CARATS (Counselling, Assessment, Referral, Advice and Throughcare) team and Substance Misuse the next day when a second prescription would be started to aid withdrawal.

Two members of staff in the First Night Centre saw the prisoner. Neither had any concerns. They explained the First Night Centre regime to the prisoner and offered him a phone call, which he refused.

The prisoner was allocated a cell with another person who had travelled with him from Chesterfield Magistrates' Court. The cellmate said that the prisoner was subdued. The cellmate found this understandable as he knew that he was grieving over the death of his girlfriend. The cellmate was only in a shared cell on the First Night Centre for approximately 10 minutes when he was asked by landing staff to move to another cell. He did not know why he had to move.

Another prisoner who also knew the deceased accompanied him from Chesterfield Magistrates' Court. He recalls him as not being his normal happy self.

This prisoner was initially allocated a cell with someone else who he had met before at Nottingham Prison and knew he did not get on with. Hence he requested a move. An officer who knew both this prisoner and the deceased allowed them to share a cell.

The new cellmate described how the prisoner had had a very disturbed night. He said how he was missing his girlfriend. He ate all of his own food as well as his cellmate's and took all the tablets he had been given. He was sick during the night and was sweating copiously. The cellmate was concerned about the prisoner's state of health and next morning told an officer about his vomiting and disturbed night. The officer offered to talk to the prisoner but he denied he had any problems. The cellmate was full of praise for the officer's concern.

On Friday 14<sup>th</sup> May, the same officer worked all day on the First Night Centre. He had spoken to the prisoner the previous evening in Reception. He knew about his bereavement, had seen the girlfriend's photograph in a frame that the prisoner carried with him and had noted the fact that he had been abusing drugs. The officer knew him from previous sentences and did not consider him depressed or suicidal.

Also on duty in the First Night Centre on Friday morning was another officer who knew the prisoner. He asked him why he was back in prison. The prisoner said that he had not got a problem with being in custody although he said that he had let himself down by lapsing into drugs quite severely. He mentioned his bereavement but said he was dealing with it in his own way.

Despite saying that he did not wish to use the phone system on reception, the prisoner did take advantage of a free phone call on Friday morning. The transcript shows that he spoke to a friend to ask for some money to be sent to him and for his clothes to be stored.

The prisoner was interviewed by a nurse from the Drug Harm Reduction Team on the Friday morning. She established what drugs the prisoner was withdrawing from and gave him a "symptomatic pack": three drugs to deal with pain, nausea and to assist with sleep. She also checked with the doctor that the prisoner would receive Lofexidene to ease withdrawal. She discussed with the prisoner why he had been prescribed Diazepam by his GP. He told

her that he had lost his partner in a road traffic accident in February and as a consequence he was suffering from depression and anxiety. They had a brief discussion at which the prisoner said that he was coping. The nurse remembers him saying, "Obviously I'm grieving. I'm not suicidal or anything, but I'm not very happy about being in prison".

The prisoner was then interviewed by a member of the CARATS team. He told her that he was grieving for his partner who had died in a flat as a direct consequence of a road traffic accident. She asked him if he was suicidal, to which he replied that it was not something that he would consider doing because he knew his girlfriend would be watching and she would not want him to commit suicide and that she would want him to prove to her that he could get off the drugs and sort himself out. The nurse advised the prisoner to see the Chaplain, which he said he had already done and that he was being put forward for a bereavement course.

Sometime during Friday afternoon the prisoner was moved on to the Detox landing. An officer who was working there recalls that the deceased was put in a cell with another prisoner. He noted that there were a number of Chesterfield prisoners on the landing who got on with the prisoner who died but no one voiced any concern about him.

The cellmate shared a cell with the prisoner on the Detox landing from Friday afternoon onwards. He recalls the prisoner telling him how his partner had died as a result of a car crash. The cellmate thought he was coping. However, he was under the impression that the prisoner was on a suicide watch, which he was not. On Friday night they sat up talking and "had a laugh" as neither could sleep because of drug withdrawal.

Another officer who worked on the Detox unit on Saturday 15<sup>th</sup> recalls that both the prisoner and his cellmate were on association. At the time, the prisoner asked the officer for a letter. The prisoner went to collect his meal and on return he collected his letter. The officer recalls the prisoner being happy about receiving the letter. He remarked that he was coping well with his withdrawal from drugs. The officer had no concerns about the prisoner and no one else voiced any concerns about him.

Another prisoner who exercised with the deceased recalls that on the Saturday the deceased had been upset about a conversation he had had with another prisoner about his girlfriend's death.

That day the deceased prisoner wrote two letters, one of which was addressed to two friends. In the letter, he said he had almost completed his withdrawal from drugs, stating how easy it was. He asked for addresses from the back of his diary, made plans where to live on release, and asked one of the friends to visit him the following Thursday when he was to appear again at Chesterfield Magistrates Court. He stopped writing and resumed the letter at 4pm on Saturday 15<sup>th</sup>. He said how he had seen others from Chesterfield on association and had put them straight about his girlfriend. He then described his plans for the future on release and asked for his mother to be contacted

for some money. The other letter was addressed to two other friends, thanking them for looking after him, saying that he was in a bad way over his girlfriend and denying stealing from them. He requested that his clothes be given to another friend for safekeeping and asked for them to look after his effects especially his photographs of his girlfriend.

### **The incident**

On the evening of Saturday 15<sup>th</sup>, the prisoner and his cellmate were locked in their cell after the evening meal at approximately 5.40pm. The cellmate had not slept since Wednesday. He had the bottom bunk, while the prisoner had placed his mattress on the floor. The cellmate took his medication and fell into a deep sleep, the time of which he gauged from the radio to be between 7.30 pm and 8.00 pm. He awoke approximately 2½ hours later to find the prisoner hanging by a bed sheet from the window bars. He attempted to undo the ligature but failed and said that it was clear to him that the prisoner was dead. The cellmate then used the cell call system and kicked the door. His perception was that it took 15-20 minutes for an officer to answer, whereupon he went away and did not return with assistance to open the door for another 15-20 minutes.

That evening, at about 10.25, an officer saw the cell light for the prisoner's cell. He approached the cell and opened the cell door observation flap and was told of the death by the cellmate. He sprinted some 20 yards towards the centre and met a number of officers who were about to respond to another matter. They all ran instead to the prisoner's cell.

Together, they lifted the prisoner and cut the ligature, using a prison issue ligature knife. They lowered him to the floor by which time a Healthcare Officer who had been previously called to attend another prisoner arrived and immediately began to apply cardio pulmonary resuscitation (CPR). He continued to apply CPR until the paramedics arrived at the prison. The incident log registered the ambulance arriving at 10.45 pm.

The prisoner was pronounced dead by the prison doctor at 10.55 pm. No suicide note was left.

### **Post incident response**

The ambulance arrived within 20 minutes of the discovery of the prisoner hanging in his cell. The Duty Governor was informed at 10.35pm. The Governor and the Chaplain arrived at the prison at 11.25pm. The doctor arrived at 10.48pm and pronounced the prisoner dead at 10.55pm.

The Police arrived at 10.48pm and the Police Liaison Officer at 11.40pm.

The Action sheets that are used as part of the Contingency Plans indicate that all people or agencies that are required to be informed of a death in custody were contacted. The control room staff maintained a log of relevant actions and events.



The Governor wrote to the prisoner's mother offering his condolences and inviting members of the family to the prison. This meeting took place and was appreciated by the family.

A commemorative service for the prisoner was held in the Chapel at the request of a number of prisoners from Chesterfield.

Two members of staff saw the prisoner's cellmate on 16 May. He was given support and facilities for contacting friends and family.

### **Levels of compliance**

This section reviewed the extent to which policies and procedures at Leicester are compliant with Prison Service policy and the local strategy for the care of the suicidal.

### **Suicide and Self-Harm Prevention Standard**

The last complete audit to be carried out by the Standards Audit Unit took place on 18 March 2003. This module received an acceptable rating.

A self-audit was completed on 3 February 2004, which generated a score of 88%. It was noted that Leicester had a "strong and pro-active Suicide Prevention Coordinator who works hard to reduce self-harm". It also noted that there is a good Listener scheme in place. The self-harm training programme was described as "hit and miss" with some staff going lengthy periods without training.

### **Contingency Plans**

The action sheets that were used at the time of the incident were a mixture of the contingency plans written prior to April 2004 and the revised edition after April 2004.

### **Suicide and Self-Harm Policy**

HMP Leicester has a very comprehensive "Caring for the Suicidal and Those at Risk of Self Injury Policy", which is published and available to all staff in all locations. A copy is also available in the library for prisoners. It contains all the information relating to recognising at-risk prisoners, raising the F2052SH forms and progressing them, and notes the responsibility of all staff in preventing self-harm.

The Listener Scheme, composition and responsibilities of the Suicide Prevention Management Team, information for dealing with a self-harm incident, care for staff and prisoners and the establishment's policy statement are all included in this document. It was last reviewed in February 2004.

### **Suicide Prevention Team Meetings**

The Suicide Prevention Management Team meets monthly. However, the membership of the meeting does not reflect the policy documents. The last three meetings have no record of attendance for the escort contractor representative.

### **F2052SH System**

The system for dealing with at-risk prisoners at HMP Leicester fully reflects the national guidelines.

### **Listeners**

There is a well organised and active Listener scheme available in the prison. Listener representatives are encouraged to attend the Suicide Prevention Meetings and there are notices around the establishment alerting prisoners to the scheme.

## **Findings**

### **Issues directly related to the prisoner's death**

At approximately 10.20 pm on Saturday 15<sup>th</sup> May the prisoner's cellmate awoke from the first sleep he had achieved in three days because of his withdrawal from drugs. He had been asleep since approximately 8.00 pm. He turned on the light to find the prisoner hanging from the window bars.

The landing was in the process of being refurbished to bring all cells up to the safer cells standards. Eight of the ten cells had their windows covered with perspex, along with being fitted with furniture that did not provide ligature points. The prisoner's cell was one of the two cells that were awaiting conversion.

The cellmate raised the alarm after trying and failing to get him down from the bars. The cellmate was of the opinion that the prisoner had been dead for some time. The response by the night staff was immediate. The prisoner was cut down using a prison issue "fish knife" within minutes of the alarm being raised. Some time earlier the Healthcare Officer had been summoned to the wing to see to another prisoner. Fortuitously, he arrived on the wing shortly after the prisoner's cell door was opened and was able to administer CPR as soon as he was cut down.

There was only a 20-minute gap between the Healthcare Officer commencing CPR and the paramedics arriving to minister to the prisoner.

### **Other issues of relevance**

The prisoner was remanded to HMP Leicester on 13<sup>th</sup> May 2004 for having breached a drug treatment and testing order imposed for offences of handling stolen goods and obtaining property by deception.

In February 2004, his partner had died of a drugs overdose. He was deeply affected by her death. By his own admission he had increased his drug usage considerably. He admitted to a heroin habit costing £50 - £100 per day.

The prisoner was no stranger to HMP Leicester, some of the staff knew him well, and he was acquainted with and friendly towards a number of prisoners from Chesterfield. He was interviewed by the Reception Officer who knew him, the doctor, the duty nurse, the First Night Landing staff, the CARATS worker, the Detox nurse and landing staff. All noted that he was subdued and he told various members of staff and prisoners about his girlfriend's death, with differing degrees of detail. All of the staff that he told asked him whether he was in danger of self harm or suicide. To each one he insisted that he was coping and went as far as telling the CARATS worker that he would not contemplate suicide as his girlfriend would not want him to do so, but to get himself free of drugs.

The prisoner spoke to other prisoners about the death of his girlfriend, but none of them thought him suicidal. He telephoned friends to make provisions for his property and wrote two letters. Neither letter was dated. One letter stated that he was not coping well. The timing of the second half of the letter can be established, as the prisoner alludes to criticism levelled at him about his girlfriend's death that he received on association. One of the cellmates' statement reveals this to have happened on Saturday 15<sup>th</sup>. At 4pm - some five to six hours prior to taking his life - the prisoner resumed the letter. In it, he suggested plans for the future, offering a visiting order to the recipient and asking her to get his mother to send him money.

## **Conclusions**

There is little doubt that the prisoner was deeply affected by his girlfriend's death. The Coroner's verdict was that it was due to an overdose of drugs. She had been in a car accident but that was not a contributory factor to her death. It is believed the prisoner had introduced her to drugs and he had felt excluded by her family at her funeral.

The prisoner's drug abuse increased to a dependency of £50 - £100 per day. He was also being prescribed Diazepam by his GP for depression. He seemed to be coping with his girlfriend's death by telling others that it was due to the car accident and by increasing his use of heroin.

When he was remanded to HMP Leicester, he told staff, prisoners and correspondents that he was coping. However, he was faced with the truth about his girlfriend's death by other prisoners from Chesterfield. Someone had doubted his explanation of the car accident on the Saturday afternoon exercise. He did not have the solace of being able to turn to the oblivion of heroin abuse as a coping mechanism. Everything pointed to the fact that he was coping: he told others he was coping and from his letters he was convinced himself he was coping. At some point between 7.30 pm and 10.00 pm on Saturday 15<sup>th</sup> May 2004 it seems probable that he realised that he could no longer stay in denial about his girlfriend's death and, without any help from others because he had rejected it, or any support from his heroin abuse, he hanged himself. This action was impossible to predict by the authorities, nor do I believe that the prisoner knew he was going to do it himself, until he came to the decision.

## **Good practice**

The care and concern for the prisoner's family, including the action of placing fresh flowers in the cell for their visit, was notable.

## **Senior Investigating Officer**