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

Report by the Prisons and Probation Ombudsman for England and Wales

March 2009

This is the report of an investigation into the death of a man, who was found hanging in his cell at HMP Featherstone in July 2008. He was in his middle to late twenties and serving an indeterminate sentence for public protection.

I would like to offer my personal condolences to the man's family, friends and everyone affected by his death.

The investigation was undertaken by two of my colleagues. I would like to thank the Governor of Featherstone and his staff for their participation. The South Staffordshire Primary Care Trust asked a lady to undertake a review of the man's clinical care, and I am also grateful for her contribution to my investigation.

It came as a great shock to the man's peers, and the staff with whom he had contact, that he should have died apparently at his own hand. He presented as a private, happy, person who had a close circle of friends and got on well with everyone. He was not subject to any special monitoring or support in respect of self-harm. However, he had been experiencing mental health problems and been prescribed appropriate medication.

I make six recommendations in this report. One repeats a recommendation I have made in a previous report about a death at Featherstone, and concerns first aid training for staff.

In the main, I judge that there was a good level of care shown towards the man. Nevertheless, his death – like others I have investigated in category C prisons – is a reminder that the risk of suicide and self-harm can apply in all prisons and not just those that take prisoners direct from the courts.

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

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SUMMARY

It seems that the man started using cocaine on a recreational basis when he was 15. From the age of 21 he began to use heroin. This led to him becoming embroiled in a lifestyle to fund his drug addiction which had led to one previous experience of custody.

On 25 September 2006, he was sentenced on 25 September 2006 to an indeterminate term of imprisonment for public protection (IPP). He was due his first parole review on 28 June 2009.

After first being received at HMP Blakenhurst, the man moved to HMP Featherstone in February 2008. He had been diagnosed with mental health problems and was taking medication. On arrival at Featherstone, he was referred to the Mental Health In Reach Team and was assessed on 1 April. However, the man failed to attend three subsequent appointments.

In July 2008, the man suffered from a headache and diarrhoea and was given appropriate treatment by healthcare staff. Two days later, he was seen by several prisoners and last seen by staff at 8.00pm when his single cell was locked for the night. There were no reports or indications that he was different in any way and no one expressed any concerns.

Early the next morning, the member of staff carrying out the first roll check and her colleagues who went into his cell found him hanging. It was apparent to them all, despite the fact that none was first aid trained, that he had died. No cardio pulmonary resuscitation (CPR) was attempted. Paramedics were called at 5.30am, and arrived 20 minutes later at 5.50am. When they reached the man's cell at 6.00am, they found that rigor mortis had already set in and they formally pronounced his death.

My report includes six recommendations.

THE INVESTIGATION PROCESS

1. The investigation was opened at HMP Featherstone in July 2008, by two of my investigators. They undertook a familiarisation tour of the prison and Houseblock one where the man resided. All documents relating to him were examined, including his medical records. Notices were issued informing staff and prisoners of the investigation and inviting anyone with information to come forward. There were no responses to these notices.

2. During the familiarisation visit, the investigators met a number of staff including managers, local branch representatives of the Prison Officers' Association (POA), and the Independent Monitoring Board (IMB).

3. All three investigators, subsequently visited Featherstone on 12 August to speak to the Governor, staff and prisoners. Four prisoners and five members of staff were interviewed.

4. A clinical review of the man's health needs and care was conducted by the Clinical Reviewer of the South Staffordshire Primary Care Trust (PCT).

5. One of my Family Liaison Officers (FLOs) contacted the man's mother by telephone and letter to explain the purpose of the investigation and to offer the opportunity of a visit to discuss my inquiries. I hope that this report addresses all the questions that the family have.

HMP FEATHERSTONE

6. Featherstone is a category C closed training prison for adult men, situated approximately six miles north of Wolverhampton. It holds a maximum of 679 prisoners. The prison was built in 1976 and adjoins Brinsford Young Offenders Institution.

7. Featherstone has seven Houseblocks. Houseblock one, where the man's cell was located, is the voluntary drug testing unit. Houseblock two holds a voluntary testing unit and close observation unit. Houseblocks three and four are classed as normal location, Houseblock five is the induction and reception unit, and Houseblock six is the enhanced unit. Houseblock seven is known as the healthy living unit.

8. Featherstone holds a number of prisoners who have been sentenced to an indeterminate sentence of Imprisonment for Public Protection (IPP) and who have no automatic right to be released. Such prisoners must serve a minimum period of imprisonment to meet the needs of retribution and deterrence. This period is announced by the trial judge and is known colloquially as the 'tariff'.

9. No IPP prisoners can expect release before their tariff expires and, even then, the Parole Board must be satisfied that the risk of harm posed to the public is reduced and manageable. This means that some prisoners could remain in prison for lengthy periods beyond their tariff to prevent further harm to the public.

10. Featherstone's healthcare department is part of South Staffordshire Primary Care Trust. Although it does not have in-patient facilities, it provides a wide range of primary care services which include health promotion and management and treatment of all chronic and acute medical conditions. Featherstone does not have 24 hour healthcare facility.

Mental Health In-Reach Team

11. Shropshire and South Staffordshire Foundation NHS Trust provides specialist mental health care to the prison. The Mental Health In-Reach Team comprises Community Psychiatric Nurses (CPNs) and a consultant psychiatrist. The CPNs work closely with Registered Mental Health Nurses (RMNs) to assess prisoners with potential mental health problems.

Assessment, Care in Custody and Teamwork (ACCT)

12. ACCT has been introduced at all prisons as a documented process to monitor and support prisoners assessed as being at risk of suicide or self harm. (The previous system was known as the F2052SH procedure.) Once placed on ACCT, the prisoner is observed at intervals determined by their perceived level of risk.

13. Each prisoner is assessed within 24 hours and then reviewed at further intervals decided on an individual basis. The ACCT guidance says that, to be effective, the review should involve the people who know the person at risk or are involved in their care.

14. The man was never considered at risk and therefore an ACCT document was not opened during his time in custody.

Night State Procedures/Contingency Plans

15. In common with all other prisons, Featherstone has night state procedures. They provide instructions to staff on how to carry out their duties and contingency plans to deal with emergencies.

Listeners

16. A number of prisoners in more or less every prison are trained and supported by the Samaritans to be Listeners to offer peer support. Other prisoners can speak to Listeners in confidence about any issues that affect them.

Personal officers

17. The role of the personal officer is to build up and maintain a positive relationship with prisoners. They are the first port of call for questions, complaints or advice.

Anti-ligature knives

18. Anti-ligature knives, also known as 'cut down tools' or 'fish-knives', are implements designed to cut ligatures. All staff in closed and semi-open prisons that have contact with prisoners must be provided with and carry on duty their own personal issue knife.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB). The role of the IMB is to ensure that prisoners are treated humanely and that there are appropriate and adequate programmes available to prepare them for their release. The IMB reports any concerns to the Secretary of State, and produces an annual report about the establishment.

20. The most recent IMB report for Featherstone covers the period from 1 November 2006 to 31 October 2007. It highlights the Board's concern that Featherstone received prisoners who were not suited to a category C training prison (a concern the IMB had also expressed in their previous report). The IMB said that they were very concerned about the shortages of staff in the healthcare centre despite representations by the Governor to the Primary Care Trust. On a more positive note, the IMB

welcomed the number of changes made by the Governor to the fabric and running of the prison and its increased cleanliness.

Her Majesty's Chief Inspector of Prisons' report

21. HM Chief Inspector of Prisons carried out an unannounced inspection of Featherstone in March 2006. This was a follow-up inspection to a previous visit in 2003. In her 2006 report, she found that the 'acute staffing problems' in the healthcare centre had not been resolved. At the time of his death the acute staffing problems had been resolved.

Previous deaths at Featherstone

22. The man was the third prisoner at Featherstone to have died, apparently at his own hand, since May 2007. In an investigation report into one of the previous deaths I highlighted the issue of first aid training for staff. I return to this issue in this report.

KEY FINDINGS

23. In July 2006 the man was received on remand at HMP Blakenhurst. He went through the normal reception procedure where it was noted that he was prescribed medication, receiving 16mg Subutex daily. (Subutex – buprenorphine – is a standard treatment for those who have misused opiates.) He was sentenced on 25 September 2006 to an Indeterminate Sentence for Public Protection (IPP) with a minimum tariff of three years.

24. During his time at Blakenhurst the man completed the Enhanced Thinking Skills (ETS) course which attempts to alter thinking styles and attitudes to enhance pro-social behaviour. He also attended a Building Skills course and provided negative voluntary drug tests (VDTs).

25. On 21 December 2066, the Parole Board sent him a letter explaining his parole date and how the procedure for consideration for release on licence would work. There is no entry in the prison record to show if, or how, the content of this letter was received by him.

26. Whilst he was at Blakenhurst, staff entries in his wing history sheet were generally positive. However, in the period 20 April – 9 May 2007, a Violence Reduction Form was opened as he was suspected of bullying. During this time the man was monitored very closely and there is no documented evidence of bullying or him engaging in any anti-social behaviour on the wing. The majority of the entries throughout his time in custody suggest that he was settled, caused no problems and had developed into a regular routine.

27. On 11 April 2007, it was noted in the man's Inmate Medical Record (IMR) that he was displaying signs of insecurity, paranoia, hallucinations and psychosis. He was prescribed 20mg of fluoxetine daily. (Fluoxetine is an anti-depressant used for the treatment of depression, obsessive compulsive disorder and panic disorder.)

28. The man received a full mental health assessment on 8 May. It was recorded in his IMR, in the section entitled "clinical impressions", that he had "drug induced psychosis", and "a long history of drug abuse". The man was subsequently seen by the prison doctor on 16 May, when he was prescribed 1mg of resperidone, a drug used for the treatment of psychotic disorders, and 50mg of trazodone, in part used for the treatment of depression and panic attacks.

29. At a doctor's treatment review on 6 June his dosage of resperidone was increased to 1mg twice per day, and his trazodone increased to 200mg daily. It was noted that the man was experiencing no thoughts of self harm.

30. The man's medication was again reviewed on 23 October 2007. His dosage of resperidone remained at 1mg but to be taken once per day. The trazodone was not increased and remained at 200mg. At his next

medication review which took place on 3 December 2007, the trazodone was increased to 300mg.

The man's transfer to HMP Featherstone

31. The man was transferred to Featherstone on 22 February 2008 and went through the standard prison reception screening process. It was noted that he needed to be referred to the Community Psychiatric Nurse (CPN), although no referral was in fact made. It was noted that, since being in custody, he had showed no signs of self harm or of being at risk. He had transferred under normal procedures and there was no need for an Assessment, Care in Custody and Teamwork (ACCT) form to be opened. It was recorded that the man was Hepatitis C positive and a question was logged as to whether he was suffering from paranoid schizophrenia. No issues were raised over his medication.

32. In respect of his medication the man continued to be prescribed the medicines at the same levels as he had been at Blakenhurst. He was required to attend the healthcare centre daily for clinical staff to issue it to him. No reason was given in his records as to why the medication was issued to him every day, rather than his being allowed to have it in his own possession.

33. On 1 April 2008, he received a primary mental health assessment, which was conducted by a Registered Mental Health Nurse (RMN). It was noted that the man felt paranoid and depressed, although he expressed no thoughts of self harm. As his mood was low, he was referred to the doctor for a review of his medication in case the dosages were excessive. He was also referred to the Mental Health In Reach team.

34. At interview with my investigating officers, the doctor who met the man said that he first met him on 4 April 2008 for a medical review. This resulted in the man's trazodone medication being reduced from 300mg to 250mg at his request. The medication was further reviewed on 18 April. The doctor again reduced the trazodone to 200mg, and on 2 May it was reduced further to 150mg. All these reductions were at the request of the man. There is no specific reason noted in the medical record as to why these requests were made.

35. He was later given an appointment to attend the healthcare centre on 22 May to see the CPN in the In-Reach team. However, he failed to attend because he was on a course. The appointment was rearranged for 9 June, but again he failed to attend. No reason was noted on this occasion. At interview with my investigators the doctor said he was not informed that the man had failed to attend any of his appointments with the Mental Health In-Reach team.

36. On 26 May, whilst collecting his medication from the healthcare hatch the man was seen attempting to conceal trazodone in his mouth. Nursing staff confirmed to my investigators that prisoners attending the

hatch for the issue of prescribed medication are supervised as much as possible. They explained that medication, which the prisoner puts in his mouth, is given in one clear container. Water is then given in a second container to help the prisoner swallow the medicine.

37. When the man was challenged by the nursing staff about concealing his medication, he immediately consumed it and said he wanted to save it for later as it made him sleepy. Staff warned him of the consequences of any repeated behaviour.

38. Another appointment was made for the man to see the CPN on 17 June. When he failed to attend at the given time, healthcare staff contacted the Houseblock staff and was told that he had been locked in his cell and the message would be passed on. No further explanation was recorded.

39. A (CPN) told my investigators that she had asked one of the Primary Care RMNs, to remind the man about his appointments. The (CPN) had no recollection of whether this was done or not.

40. On 30 June, the man wrote to his mother with a visiting order. He indicated that he had plans to save money to buy an Xbox (a computer games console), and that he would find it difficult to stay off drugs on his release but he was determined to try hard. He invited his mother to attend his next sentence planning review, which was scheduled for August 2008. There was no indication in the letter of any problems that may have been affecting the man.

41. A fellow prisoner told my investigators that the man, “never showed signs about being depressed whilst at Featherstone. I think he was looking very forward to getting parole in 2009.” Another prisoner said, “the man was a joker and enjoyed a laugh. The man was looking forward to his parole time in 2009 and seemed to be taking his sentence well.” He added that the man “showed no signs to me of being depressed”. However, prisoner said that the man had stopped taking his medication in mid June 2008, “as it was making him feel like a zombie”.

42. A third prisoner said that on 3 July 2008 he saw the man in the dinner queue (around midday),”he had a really big smile on his face ... he seemed really happy to me.” A further prisoner told my investigators that the man never discussed anything that might have been a concern to him, although he did say that the man had said he was upset about his IPP status. The prisoner said that on the evening of 3 July the man appeared “stressed about something,” but he did not know what.

43. During his time at Featherstone the man generally seemed to have settled very well into the routine. At interview with my investigator the man’s personal officer, said that he used the gymnasium regularly, related well to staff and generally behaved well. He presented as a private, happy, person who had a close circle of friends and got on well with everyone, giving no indication that he was at risk. The man also

attended the healthcare centre frequently for a variety of other reasons (in growing toenails, taking of medication and medical reviews). My investigation has uncovered no concerns noted by staff about self harm.

Events of 3/4 July

44. The night duty staff commenced duty at 7.45pm and all staff reported a quiet night. The person in charge of the prison during the night was a Senior Officer (SO).

45. The role of Operational Support Grade (OSG) staff on Houseblocks is to conduct regular patrols of the unit from 8.00pm until 6.00am, check prisoners who are on open ACCT documents, attend to those who summon them via their cell bells, and to be the first response in the case of emergency. There is no requirement to check prisoners who are not on an ACCT form. The OSG night staff do not hold cells keys but carry a sealed pouch, containing a cell key, which allows them to gain access to a cell in an emergency.

46. At approximately 5.10am, an OSG commenced her morning roll check to ensure that all prisoners were accounted for. At 5.20am, she arrived at the man's cell and looked through the observation panel. She saw him hanging from his bed frame.

47. Staff confirmed to my investigators during interview that the procedure for night OSG staff at Featherstone who find a prisoner hanging is to summon assistance, using their radio and via the Control Room, rather than immediately entering the cell because of the risk to security. The OSG used her radio to call "Code Blue" (an indication that someone is having breathing difficulty) which was answered by the SO and a prison officer. Both staff arrived at the man's cell on Houseblock One at approximately 5.25am. When they arrived the OSG broke her sealed pouch to reach her cell key which was used to open the cell door.

48. The officer and S/O went into the cell and the S/O supported the man whilst the officer cut the ligature tied to the man's neck. They examined him and found his body was "very cold and very rigid". Despite the fact that both members of staff were not first aid trained, they believed that he had died. No attempt was therefore made at cardio pulmonary resuscitation (CPR).

49. The S/O instructed the Control Room that the death in custody contingency plans were to be activated. The paramedics were called, along with all necessary agencies, including the Governor and the police. The paramedics arrived at Featherstone at 5.50am and confirmed that rigor mortis had set in. They pronounced that the man had died at 6.00am.

After Mr the man's death

50. As part of the death in custody plan the man's cell was sealed to await the arrival of the police and a log keeper was appointed. Having been informed of his death, the Governor made his way to the prison.

51. When the Governor arrived, he ensured that arrangements were made to brief all staff and prisoners on the unit about the man's death. A "hot debrief" was held in the Governor's office during which the events of the morning were discussed with staff involved. These members of staff were offered the services of the prison's Care Team.

52. The police arrived at 6.30am. A note was made by the police on the Property Scene Summary acknowledging that they were satisfied that there was nothing to suggest any third party involvement.

53. Arrangements were made to inform the man's next of kin. The Deputy Governor, the prison's Family Liaison Officer, Chaplain and Principal Officer (PO) visited the family home (arriving around 10.00am) and informed them of the circumstances of the man' death.

54. During the visit, the family were given the contact numbers for the prison, including those of the Deputy Governor and a funeral director. They were offered the opportunity to visit the establishment and offered assistance with the costs of the funeral.

55. The man's funeral was held on 27 July. The prison was represented by the Deputy Governor and the Principle Officer. Prisoners organised a collection and a wreath was purchased as a mark of respect. Additionally, on Wednesday 10 September the Chaplain held a memorial service for the man which was attended by his mother.

Post Mortem and Toxicology Report

56. The Post Mortem examination concluded that the cause of his death was"hanging". The toxicology report, in the analytical results section, showed that trazodone was detected but that the concentration measured was within therapeutic limits. There is no suggestion of any other substance being detected.

ISSUES CONSIDERED IN THE INVESTIGATION

The man's IIP status

57. There were suggestions from three prisoners that the man was affected by his IPP status and that it was a matter of concern to him. None of the prisoners could say exactly what his concerns were. Similarly, the comment made by one of the prisoners that, on the day before he died the man was "stressed about something," is not confirmed by other staff or prisoners. There was no other evidence to indicate anything unusual in his behaviour. He seemed to staff to be "his normal self" and made no mention of being upset or worried.

58. There have been concerns in a number of quarters that the IPP sentence may itself present a risk to safer custody. In the man's case I note the suggestions made by the three prisoners, but I am unable to conclude whether his IPP status had any bearing on his apparent decision to take his own life.

Clinical care

59. The man was transferred to Featherstone on 22 February 2008 and in reception had a primary mental health assessment. At this assessment, it was noted that a referral to a CPN or a psychiatrist was required. This referral was never made. Only when he was seen by a Primary Care RMN on 1 April was he referred to the Mental Health In-Reach team, although he failed to attend three subsequent appointments. In the meantime, he was seen regularly by a doctor for medication reviews, and his medication was reduced at his own request. His non-attendance at appointments with the In-Reach team was not brought to the doctor's attention. It would benefit patient care for a clear process for referrals to mental health services to be instigated, and for other clinicians to be made aware that patients are not keeping appointments.

60. It is self-evidently important that prisoners attend scheduled healthcare appointments to ensure they are properly assessed and offered the correct level of care and treatment needed. If, for whatever reason, a prisoner fails to attend scheduled appointments, this should be recorded, and the information shared and acted upon to ensure any problems that may have arisen are addressed.

    A clear process should be introduced for referring people to mental health services when the need is identified at the reception health screen.

    Doctors should be informed when prisoners fail to attend mental health appointments.

61. The man failed to attend three appointments with the CPN, despite on one occasion Primary Care staff being asked to remind him to attend.

The Clinical Review Panel concluded that misunderstandings of this nature would be alleviated by formal handover arrangements between Primary Care and the In-Reach team. Failures to attend mental health In-Reach appointments should be raised in handover procedures and documented in the prisoners' medical records.

62. One of the healthcare team reports in a statement regarding the man's death that he had attended the healthcare department on 2 July, complaining of diarrhoea and vomiting. This contact is not recorded in the IMR. The clinical review panel also found that numerous entries in the medical records were illegible or had not been signed.

All medical records should be complete, accurate and signed and dated by the person making the entry. The entry and signature must be legible and made in line with good record keeping standards.

Whether the man was taking his medication

63. If prisoners are suspected of not taking their medication they are asked to open their mouths so that healthcare staff can check. Any concerns should be submitted to the Security Department on a standard Security Information Report (SIR), the prisoners' records noted and another risk assessment carried out. No SIR was submitted when the man was spotted trying to hoard his medication and therefore no follow up action was taken. I judge that a formal reminder to staff would be sensible.

The Governor should remind staff to take all reasonable measures to ensure that medication is taken in front of them.

64. Despite the man attending the healthcare centre daily, a fellow prisoner said that he had stopped taking his medication in mid-June 2008, "as it was making him feel like a zombie". Should this be true, it was not noticed or noted by staff except for the one occasion on 26 May when the man was seen attempting to conceal his trazodone. There is no other evidence to suggest that he was not taking his prescribed medication.

First aid training

65. None of the staff who discovered him was first aid trained. CPR was not attempted as, after examination, it was believed that he had died. I believe that, in this case, staff would not have been able to resuscitate him even if they had been trained.

66. However, in a previous investigation report that was issued in January 2008 following a death at Featherstone, an establishment without 24 hour healthcare facilities, I recommended that a cross-section of staff that come into contact with prisoners on a daily basis should be trained in first aid. The prison accepted the recommendation with a completion

date of October 2008. The first group of staff to be trained are the Senior Officers who assume control of the prison during periods of night duty. Training for these staff has commenced and should have been completed by 19 September. Training for other staff has yet to be completed and so I repeat the recommendation here.

A programme of first aid training for a cross-section of staff (especially night staff) who have contact with prisoners should be rolled out with immediate effect.

Contingency plans

67. Featherstone's death in custody contingency plans are confusing in that they appear to have been written for another prison. For example, they refer to alerting the healthcare centre during the night but, as I have said, Featherstone does not have 24 hour healthcare and so this is impossible. The plans also require staff to ask for "immediate medical assistance and first aid equipment and give your location", even though there are no healthcare staff on duty.

68. The First on the Scene (Night State) plan is not entirely clear as to whether staff should enter single cells when they are on their own. The contingency plans refer to the communications officer calling an ambulance for "HMP The Mount", rather than to Featherstone. Contingency plans need to be clear and accurate so staff can use them to act immediately and effectively in emergencies.

The Governor should review the contingency plans and ensure that they are accurate and applicable to HMP Featherstone.

RECOMMENDATIONS

To the Primary Care Trust

1. A clear process should be introduced for referring people to mental health services when the need is identified at the reception health screen.

2. Doctors should be informed when prisoners fail to attend mental health appointments.

3. All medical records should be complete, accurate and signed and dated by the person making the entry. The entry and signature must be legible and made in line with good record keeping standards.

To the Governor

4. The Governor should remind staff to take all reasonable measures to ensure that medication is taken in front of them.

5. A programme of first aid training for a cross-section of staff (especially night staff) that has contact with prisoners should be rolled out with immediate effect.

6. The Governor should review the contingency plans and ensure that they are accurate and applicable to HMP Featherstone.