Investigation into the circumstances surrounding the death of a male prisoner at HMP Gloucester in June 2005

Prisons and Probation Ombudsman for England and Wales

November 2005

This report concerns the circumstances surrounding the death by hanging of the man at HMP Gloucester in June 2005. He left a suicide note addressed to the mother of his two children. It appears that he could not face the 18 months imprisonment to which he had been sentenced the previous day, and the consequent separation from his partner and children.

I would like to extend my condolences to the man's partner, parents, brother and sisters and other family members for their loss.

The man was 39 years of age. He had been in custody only a little over 24 hours when he was discovered hanging by a sheet from the bars of his cell. He had been identified as at risk of suicide or self-harm at court, and was the subject of the prison's suicide and self-harm monitoring at the time of his death. The risk was based on the man's admission to staff at both court and prison that he had taken two overdoses of medication in the four weeks prior to his imprisonment.

From what we learned from the man's mother, we now know that one of the overdoses was life threatening and resulted in a hospital admission. The man told his brother, who visited him in hospital that he wished he had not been resuscitated. It appears that, despite denying to prison staff any suicidal intention, he may have been determined on the course of action which resulted in his death so soon after being imprisoned. Unfortunately, prison staff did not identify his state of mind sufficiently accurately to raise the level of suicide prevention they provided, and he was alone in his cell giving him the opportunity to take his life.

The investigation was carried out by one of my investigators, a qualified nurse, who works for my office. West Gloucester PCT provided a clinical review and my thanks go to them for their report. I would also like to thank the Governor of HMP Gloucester, and his secretary for their co-operation with my investigation. The Safer Custody Manager, gave invaluable support.

I commend the man's co-defendant for his actions in raising the alarm and helping the officers who attended in the first instance. The officers and nurses who attempted to resuscitate the man also acted swiftly and competently.

I make eight recommendations arising from these sad events.

STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN **November 2005**

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SUMMARY

1. The man was born in 1966, the second of five children. He was married and had three children, but he had separated from his wife some five or six years before his death. No divorce had been finalised, but he had made a new life with another woman, with whom he had two children. At the time of his conviction, the man was living in Worcestershire but his partner had moved back to her mother's home.

2. The man was convicted of assault and affray in June 2005. and sentenced to 18 months imprisonment. He had a number of previous convictions for similar and drug related offences. He had served a previous period of imprisonment in 2001.

3. The man was received into Gloucester in the late afternoon on 13 June, having previously been on bail. He arrived at the prison with his co-defendant, who had received a similar sentence, but who had been remanded in custody prior to their trial. The man was the subject of a Suicide/Self-harm Warning Form, completed by a custody officer at the Crown Court, because he had revealed that he had tried to commit suicide by overdose twice in the previous four weeks. The reception officer at Gloucester opened a Suicide and Self-harm Monitoring Record (F2052SH) for the man in response to the warning form. The man was allocated a shared cell on A wing for his first night in custody, and placed on level three suicide and self-harm risk monitoring observations.[1]

4. During the afternoon of 14 June, The man's cellmate was moved to another wing to be with a relative. The man had not been identified as 'requiring constant company' an arrangement set out in the local policy on suicide and self-harm prevention.[2] However, officers were planning to move another prisoner in with the man before locking up for the night. The man was spoken to by an officer at 5.00pm when he collected his tea, and he gave the officer no cause for concern. In the early evening of 14 June, The man's co-defendant went to see him and found him hanging in his cell.

5. His co-defendant called for help without delay. Officers came at once, entered the cell and were able to remove the sheet with which the man was suspended from the window bars. Nursing staff also attended almost immediately and commenced cardio-pulmonary resuscitation. Despite their strenuous efforts and the continued actions of the paramedics who also arrived very swiftly, the man could not be revived. The paramedics recorded that they had informed the prison doctor 'for recognition of death'. However, no doctor attended the prison before the man's body was removed to the hospital by a funeral director.

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[1] Level three observations entail the prisoner's state and mood being observed at morning unlock, during each period of the day (morning, afternoon, evening), when the night patrol takes over from the day staff, and at least five times during the night.

[2] Prison staff can designate that a prisoner needs constant company based on their assessment of his mood and behaviour. If requiring constant company, the prisoner must always have company, ie he must not be left alone if his cellmate goes to an activity or appointment elsewhere in the prison or outside.

6. Following the man's death, the Governor arranged through the prison's police liaison officer that West Mercia police would inform his partner whom he had stated was his next of kin. The police broke the news and asked her to ring the Governor. Her mother was with her when the news was broken. She and her mother undertook to contact the man's parents, although in the event the only person they could contact was the man's sister. Subsequently his partner visited the prison accompanied by the man's brother. The Governor followed up the visit with a letter of condolence, and later undertook to fund the funeral expenses. A representative from the prison attended the funeral in July.

7. A post mortem on 16 June concluded that the cause of death was hanging.

8. As a result of this investigation, I make eight recommendations for policy and practice, mainly in relation to suicide prevention.

THE INVESTIGATION

9. The investigation began on 16 June when the investigator contacted the Governor's secretary and the Safer Custody Manager. On 21 June, notices were issued to staff and prisoners announcing the investigation and inviting anyone with information relevant to the man's death to contact the investigator.

10. One of my Family Liaison Officers (FLOs), attempted to contact the man's next of kin by telephone. Unable to make that contact, she wrote to his partner on 13 July. She explained the role of the Ombudsman and the Family Liaison Officer and invited her to contact us if she wished to raise any questions or concerns. We have had no further contact from her.

11. My investigator visited Gloucester on 27 June, familiarising herself with the prison - particularly A wing where the man died - and meeting staff and prisoners. She was provided with all the relevant documentary evidence and local policies. When she returned on 19 July, she was provided with copies of police statements from interviews. The interviews included those with two prisoners, the man's co-defendant and his first night cellmate, who had soon been released or transferred. Their statements proved very useful to the investigation. The investigator also met with representatives of the West Gloucester Primary Care Trust to confirm the commissioning of a clinical review. She was able to meet the Governor and conduct four interviews. On 18 August, she returned to conduct three further interviews. She was also able to meet with a representative of the Prison Officers' Association (POA) and the Chairman of the Independent Monitoring Board (IMB).

12. When my investigator visited on 18 August, she was given a letter from the man's mother addressed to the Governor and a reply sent by the Safer Custody Manager. Further to that contact, the man's mother rang another of my FLOs, who arranged for my investigator to visit her at her daughter's home with the FLO originally assigned to the case. My investigator and the FLO visited the man's mother and sister on 12 September. It was extremely pertinent to the investigation to learn more about the man and his life from his family.

13. Records of the interviews were forwarded to Gloucester for staff to check, amend as necessary and sign. The investigation was completed on 14 September 2005.

14. Following the consultation on the draft report, the man's mother expressed her keenness to meet with the FLO and investigator again. A meeting took place on 7 November.

HMP GLOUCESTER

15. Gloucester is a local prison serving a wide and varied catchment area. At any time, prisoners may originate from South Wales, Gloucestershire, Worcestershire and even further afield. A total of 320 men can be held there.

16. The prison is currently subject to a performance improvement programme (PIP). This is a national initiative and the assessment of performance and consequent improvement planning is led by the Area Manager. Being subject to a PIP is not necessarily an indication of poor performance. At the time of this investigation, Gloucester was lying tenth among prisons in the whole of England and Wales on the Weighted Score Card of performance against national standards. Gloucester was the best-performing local prison in the country, and the best-performing prison in the South West Region.

17. Gloucester has experienced a very high incidence of self-inflicted deaths in the past two years. Three prisoners died within 18 days in 2004. At their inquests in May 2005, all verdicts were suicide, no riders were attached and no blame put on the prison. In 2005, there have been three apparently self inflicted deaths prior to the death of the man, plus a death by natural causes. Inquests have not yet been held.

18. The Prison Service last audited Gloucester, on selective functions, in December 2004. At that time, the management of suicide and self-harm scored 82%. The prison's self audit performance was scored at 88%, giving their audit team accreditation. The accredited team audited the prison's performance on 'Handling a Death in Custody' in July 2005, giving a score of 100%. Sadly, this level of competence has been earned through the number of occasions on which the staff have had to manage this contingency. The personal toll on staff involved with the man's death was evident during this investigation, despite excellent staff support services.

19. The Chair of the IMB raised with my investigator his concern that, in yet another death, a torn bed sheet was used as a noose. The Chair of the IMB had written to the Home Secretary with his concerns on 8 July. He received a reply from the Minister of State at the Home Office, on 18 July. The Minister's reply referred to work being undertaken under the auspices of the NOMS Safer Custody Group to develop safer bedding.

KEY EVENTS
Events prior to the evening of 14 June 2005

20. The man was on bail while awaiting his trial. He told a custody officer at court that he had taken two overdoses in the four weeks before coming to prison. His co-defendant thought that the man had come to court on 13 June direct from a hospital where he was being treated following an overdose, but this has not been corroborated. However, the man's mother confirmed that one of the two overdoses had resulted in admission to hospital. She believed that her son had had to be resuscitated. She reported that when the man's brother visited him in hospital, the man had said he wished his life had not been saved.

21. The man was made the subject of a Suicide/Self-harm Warning Form, by a custody officer at the Crown Court because he admitted trying to commit suicide by overdose twice in the previous four weeks. This was also highlighted on the Prisoner Escort Record by the same custody officer. There were no untoward events recorded at the Crown Court or on the escort vehicle.

22. The man was received into Gloucester from Court at 5.15pm on 13 June. His co-defendant reported that he was in reasonable spirits in the van on the way to prison. They had received identical sentences, but he had been remanded in custody prior to their trial, so he was facing a shorter period in custody than the man, because remand time would be deducted.

23. The reception officer at Gloucester, opened a Suicide and Self-harm Monitoring Record (F2052SH) for the man in response to the warning form. In doing so he followed the Gloucester policy on managing the risk of suicide and self-harm. He also completed a cell sharing risk assessment (CSRA). The man told the reception officer that he would rather not share a cell because of his depression.

24. The reception nurse also contributed to the CSRA. The man was deemed to be a medium risk for sharing with another prisoner. At interview, the reception nurse explained that he understood medium risk to mean that the prisoner can share a cell, but the decision needs to be reviewed on a regular basis. The assessment of risk as medium appeared to be a reflection of the man's offence history which contained some violence, his wish not to share and the advisability of sharing for someone at risk of suicide or self-harm.

25. The man affirmed that he had taken two recent overdoses and suffered from depression. He denied any current thoughts of suicide or self-harm when interviewed by the reception officer and the nurse. The reception officer consulted with the nurse and the orderly officer, who completed the page 2 management check in the F2052SH. The decisions made were that the man should be subject to level three observations, and be in a shared cell. Access to the chaplaincy and Listeners[3] was also mentioned. He was not considered to be in need of constant company as defined in the local policy.

[3] Listeners are prisoners trained by the Samaritans to support fellow prisoners at risk of suicide or self-harm.

26. The man was allocated a shared cell on A wing for his first night in custody. The man and his co-defendant were not located together. At interview, it became clear that their progress through reception was quite separate because his co-defendant was returning to Gloucester. He did not require a detailed health screen or cell sharing risk assessment, and returned swiftly to the cell which he had left that morning. During interviews, it was evident that staff were not aware of the man having a co-defendant in the prison. Neither the man nor his co-defendant raised the issue with staff. The reception officer and nurse completed the Gloucester First Night Induction form. They highlighted that a F2052SH form had been opened for the man, and that there were substance misuse and related mental health issues.

27. During his first reception health screening by a nurse the man discussed his recent alcohol and substance misuse. He was referred to the doctor for this and for a mental health assessment. The nurse recorded that he man said he was estranged from his partner, and had recently agreed access to their children. The man commenced an alcohol detoxification regime of librium and carbamazepine prescribed over the telephone. The man received the first dose that evening, and another the following morning. At interview, the nurse commented that the man must have been expecting imprisonment because he had with him a quantity of tobacco and cigarettes.

28. The man's co-defendant visited him in his cell at about 7.30am next morning, and thought he was 'comfortable' though tired from lack of sleep. They met again in the queue for meals during 14 June, and each time he seemed 'alright'. During the day, the man completed some of his induction on the wing. A prison officer on A wing, confirmed in a telephone enquiry from my investigator that she had conducted some of his induction. She remembered that he sat at the back of the room in which the induction was taking place and interacted in the sessions. She knew the man's co-defendant well because he was resident on the landing for which she was normally responsible when on duty. She knew he was the man's friend. After the man had seen the doctor later that morning, he returned to his cell and the officer spoke to the man and his co-defendant. Both assured her the man was 'alright'. She had been very shocked to hear of his death.

29. During the morning of 14 June, the man saw the doctor who assessed him and completed the appropriate section of the F2052SH and the medical record. The doctor noted that the man had been consuming '200-300 units' of alcohol per week[4], as well as stimulants. He described the man as 'quite tense' about withdrawing from stimulants and alcohol. The detoxification programme was intended to address this. The doctor signed a prescription confirming the previous verbal order, and added two further medications, fluoxetine for depression, and thiamine to counteract some of the detrimental effects of a significant alcohol intake. The man had been on fluoxetine prescribed by his general practitioner for some time previously.

[4] Department of Health advice on *sensible drinking* is 20 units a week for men

30. During the afternoon of 14 June, the man's cellmate was moved to another wing. At interview it emerged that a prison officer had moved the man's cellmate because he had successfully applied to move to share a cell on B wing with a relative. Although the man had not been identified as 'requiring constant company', the officer was planning to allocate another prisoner to share with the man before locking up for the night. On returning from B wing, the officer found the wing very busy with prisoners returning from work, visits and other afternoon activities. It was also time to serve the prisoners' meal. The officer was due to go for his break before going to reception to perform reception officer duties during the evening. He said that he made his wing colleagues well aware that the man needed a cellmate before the final locking up of the day. The officer expected that one of the new receptions that evening would be located with the man. The officer had just returned from days off, and was unaware of the man's co-defendant being on the wing.

31. The officer confirmed at interview that he made the last entry in the man's F2052SH at 5.00pm, recording that he had spoken with him when he collected his tea, and that there were no problems to report. Entries in the F2052SH had been made in keeping with the requirements of level three observations as set out in the local policy.

32. At about 6.00pm, the man rang his cell bell and a prison officer went to the cell. The man told him that his previous cellmate had taken his cigarettes. The officer went to B wing where the other prisoner was now located, retrieved the cigarettes and brought them back to the man at about 6.10pm. The officer was then on patrol on the landing, and did not actually record the event in the F2052SH. In their statements, the prisoner and the officer both confirm this event, the prisoner asserting that he had simply been recovering an equivalent number of cigarettes that he had given the man while they were sharing the cell.

33. There were no further entries in the F2052SH and the man was not seen alive after that time.

Events of the evening of 14 June 2005

34. According to his evidence, at about 6.40pm an officer was alerted by a prisoner (now known to be the man's co-defendant), shouting and screaming at the door of the man's cell and kicking the door. The prisoner stated in evidence to the police that he could see his friend was hanging at the back of the cell. The officer and his colleague opened the door immediately, and saw that a noose fashioned from a ripped sheet had been used. The man was suspended from the window bars with his feet off the floor. Another officer pressed the emergency bell (general alarm). Between the officers and the prisoner they were able to lift the man, remove the noose and lower him to the floor in the recovery position.

35. By that time, a nurse had arrived and she commenced a check of breathing and circulation. Finding neither, she commenced mouth to mouth resuscitation and a Principal Officer, who was orderly officer (effectively in charge of the prison), assisted her by doing chest compressions. At the subsequent hot debrief

convened by the Governor, it was confirmed that before he went to the cell, he had given an instruction for an ambulance to be called. At interview, another nurse told how she was working in reception when she heard the call for health care on her radio. Believing she would be needed, she quickly ensured the safe custody of the prisoner she was interviewing, before running to A wing. She went to the cell where staff were gathered and saw that resuscitation was taking place, but that the defibrillator was not there. She looked over the railings, saw an officer and called for him to bring the defibrillator at once.

36. Another officer reported in a statement that he responded to the alarm bell and on arriving at the cell was asked to get the medical bag from health care (then temporarily located in A wing on the ground floor). On returning with the bag, he was asked to take over the chest compressions, which he did. A nurse set up the defibrillator and placed the pads on the man. Being an automatic model, the defibrillator tests whether applying a shock is appropriate or not. The defibrillator instruction advised against shocking (because the heart had no electrical activity on which the shock could act).

37. Although one officer subsequently estimated the time events started as 6.40pm (18.40), the ambulance service report logged the call from the prison at 18.38 and their arrival time at the prison as 18.44. When the ambulance service paramedics arrived, they took over the resuscitation attempt but found that the man's heart was in asystole (no electrical activity present). They ceased resuscitation, and entered in their log that they had 'informed the prison doctor for recognition of death'. No time was logged but it appears to have been around 6.50pm.

38. One of the nurses recalled at interview that she had seen a note, apparently a suicide note, in the man's cell. She told the orderly officer, who ensured it went to the police as evidence. The letter was to his partner, and an envelope addressed to her was also in the cell. The man wrote of 'hurting like no-one understands' and being sentenced for 18 months for what? defending my kids'. He went on 'I can't live that long without them or seeing you'.

Events after The man's death

39. The orderly officer, reported at the hot debrief that, once he left the man in the care of the nursing staff, he had activated the relevant contingency plan. There was evidence of the contemporaneous logging of events. The Governor was informed of the death and arrived at the prison at 7.05pm, closely followed by the health care manager and a member of the staff care team. Subsequently, police officers, the Chaplain and members of the Independent Monitoring Board attended, as well as the Safer Custody Manager. The ambulance left at 7.25pm and the funeral director arrived at 11.10pm.

40. Staff opened a suicide and self-harm monitoring form for the man's co-defendant. This was a recognition of the emotional risk he was experiencing, having been a friend of the man's for about five years. The man's co-defendant had found him hanging and assisted with the immediate response by helping to take his weight while the noose was released. The Governor also arranged for

the man's partner to meet this prisoner when she visited the prison later that week. The prisoner was released from the prison on 18 July, having completed his sentence.

41. Arrangements to notify the next of kin with the assistance of the West Mercia police. The police visited the man's partner where she was in the company of her mother. The police broke the news, and asked her to telephone the prison. The Governor was assured by the man's partner or her mother that she would contact his parents. In the event, it was around midnight before she got through to the man's sister, saying she had not been able to reach his parents or brother.

42. The Governor convened a 'Hot Debrief' of the evening's events at 8.53pm, attended by all the staff who had been involved in any way plus the healthcare manager, the Chaplain and the staff care team representative.

43. The man's next of kin visited the prison on 17 June together with his brother. They met the Governor and Safer Custody Manager and visited the wing as well as sharing a prayer in the man's memory. A formal letter of condolence was written later that day, and offered ongoing contact and support. On 1 August, the Governor received a letter from the man's mother about the investigation into her son's death and the future inquest. The Safer Custody Manager replied on behalf of the Governor, offering their condolences as well as practical advice about the inquest and investigation.

KEY FINDINGS

44. The man was in a vulnerable emotional state when he was committed to prison. The depth of his distress was not readily evident to those who assessed him. In reception, he was assessed by the reception officer and a nurse. He was identified as being at risk of suicide or self-harm on his own admission of two recent overdoses. Although the nurse said at interview that he had asked what medication the man had taken neither the reception officer or nurse probed deeply. They did not ask the man how serious the overdoses were or whether he had been admitted to hospital as a result.

45. The man told the nurse that the reason he took the overdoses was that he felt under pressure because the court case was likely to result in imprisonment. This would mean separation from his family, where there were already tensions over his access to the children, following estrangement from his girlfriend. It appears in the statement from the man's co-defendant, that the couple had been very worried about the health of their daughter. The man indicated to the nurse that he was actually feeling the pressure had eased with the sentence being passed, and access to the children agreed. From the meeting with the family, we learned that the man had two families, and therefore references to access and estrangement gave no clear indication of the complexity of his situation.

46. When the man took the overdose which was apparently life threatening, he was with his partner. The man's mother was given the impression by his partner that she had been warned by Social Services that she might lose custody of the children if she continued to live with him. That was apparently the reason she had left and gone to live with her mother. They had not ended their relationship.

47. In reception, the man was identified as needing detoxification treatment for alcohol and stimulant abuse. He admitted daily use of cocaine, amphetamines and benzodiazepines to the nurse in reception. The doctor calculated his alcohol intake as ten times the recommended maximum per week for men. The detoxification programme of librium and carbamazepine was appropriate to the withdrawal symptoms he might have been expected to experience in respect of both the alcohol and the benzodiazepines. There is no recognised chemical detoxification programme for cocaine or amphetamines. The doctor described the man as quite tense about experiencing alcohol and stimulant withdrawal.

48. In the brief time he was in Gloucester, the man appeared to his co-defendant, to the doctor and to officers he spoke with, to be settling. He assured them that he was alright, and in a better state now things were settled with his girlfriend and access to his children. He stated to the nurse, reception officer and the doctor that he had no intention of suicide or self-harm at that time. The doctor noted that he was calmer in mood, having received a better sentence than expected and the family were supportive.

49. The orderly officer on the evening of 13 June, and the nurse both assessed the man as requiring level three observations and a shared cell. Level three observations were carried out. However, the man was alone in his cell from about 2.30pm to the time of his death. This was not in breach of the local suicide

prevention policy, because the man had not been designated as being in need of constant company. It was reasonable, within the terms of the policy as written, for the man to be alone for a period of time.

50. 'Requiring constant company' is described in the local suicide prevention policy in isolation from the descriptions of the three levels of observations. My investigator was told that it was applied in conjunction with both level two and level three observations. Level one is constant watch and therefore there is no need for the constant company requirement. Some interviewees did not appear totally sure about the use of the term 'requiring constant company' or its implications. There was no entry in the man's documentation to indicate whether constant company had been considered or not.

51. There was a clear intention on the part of the officer to find the man a cellmate before locking up for the night. However, this did not happen due to competing duties, and he relied on his colleagues to take over the responsibility. Responsibility for individual management of prisoners on F2052SH was not subject to written allocation on the wing. Tragically, the fact that the man was alone in his cell provided an opportunity for him to construct a noose and hang himself.

52. Staff were assured by the man that he was in better spirits, as illustrated in the exchange with an officer just before lunch, recorded in the F2052SH and confirmed at interview. The man had told the reception officer that he would rather not share because of his depression. The man's mother has put a number of events together since his death, and formed the view that he decided to kill himself because of the pressure of his family circumstances compounded by his prison sentence.

53. The nurse had referred the man for a mental health assessment. It appears that the man's solicitor did not pursue the possibility of introducing his mental state in mitigation of his offence. A form giving permission for medical records to be made available which the man needed to sign was found unsigned among his court papers by his sister.

54. Given what little the staff knew about him, it may be understandable that they did not consider the man to be in need of a higher level of observation or in their local terminology, requiring constant company. His previous attempts to take his life were by overdose, giving no hint of a risk of hanging. However, more questioning about the overdoses might have elicited the seriousness of one of them. It is possible this would have resulted in the implementation of level two observations, and a requirement for constant company. This might have prevented the man having the opportunity to hang himself so early in his sentence. And there would then have been more chance for supportive interventions and family visits which might have further reduced the risk.

55. The response when the man was found hanging was swift and competent. All staff played their part and the emergency services were called promptly and attended quickly. The man's heart showed no electrical activity, therefore an electric shock (defibrillation) was not appropriate treatment. The paramedics

confirmed this when they arrived and tested his heart. The paramedic completed a report in which he or she wrote that the prison doctor had been 'informed for recognition of death'. This did not happen. It is acceptable practice for a paramedic to declare life extinct, but the paramedic did not clearly do so on this occasion.

56. The next of kin named in the man's records was visited by the local police at the prison's request, and put in contact with the Governor. Care was taken that she was not alone at that time. It was left to her or her mother, with whom she was living, to contact the man's parents and other family. It is not clear whether she volunteered to do this, or was asked to do so. The outcome was less than satisfactory for the man's parents because she was only able to contact his sister nearly five hours after the event. The follow up arrangements for the next of kin, including a visit to the cell, a visit with the man's co-defendant and payment for the funeral were well handled.

57. Recognition of the impact on the co-defendant of being the one to find his friend hanging was shown by the opening of a suicide and self-harm risk monitoring form for him. A swift analysis of the events surrounding the man's death was instituted through a hot debrief of staff within three hours. Staff who were particularly affected by the circumstances were grateful for the support they received.

The family's concerns

58. The man's mother and sister asked a number of specific questions:

    a. Was the man's cellmate moved after a row as his co-defendant had told her at the funeral that he had heard shouting coming from the man's cell?

    b. Why was the man placed in a cell with bars and allowed a sheet?

    c. Given how recently the man had made two suicide attempts, why was he not placed on a more frequent watch particularly during the first 24 hours?

59. Following their reading of the draft report, his mother and sister also wanted to know why the officer who cut the noose did not initiate cardio pulmonary resuscitation (CPR) before the arrival of the nursing staff.

60. The answer to the first question is that my investigator found no evidence of a row between the man and his cellmate. His cellmate was moved at his own request in order to be on the same wing as a relative. The move had apparently been pre-planned, as the result of an application from the prisoner. There was evidence that the man thought the other man had helped himself to his cigarettes when he moved. The other prisoner admitted that he had taken them, and gave them back when asked by an officer, although he contended that the man owed them to him.

61. The answer to the second question is that there is a shortage of safer cells (those specifically designed without ligature points) in prisons generally. At Gloucester, my investigator was told by the health care manager of only one safer cell, located on the ground floor in A wing and currently one of the three cells being used by the health care team for their patients. The actual health care centre has been closed for many months for refurbishment. Three cells are rarely enough to meet the needs of the patients the staff believe to be in need of in-patient care.

62. The answer to the third question is the crux of the investigation. The staff clearly responded to the warning from court, and the admission from the man that he had recently taken two overdoses, by putting him on level three observations. They accepted the reports of the overdoses without further investigation. They also accepted the man's self reports as to his state of mind and wellbeing which gave no cause for concern. He gave the same reassurances to his friend and co-defendant. A more critical analysis of the man's history might have guided the staff to apply level two observations.

63. The question about the initiation of CPR has two aspects, one the particular circumstances on this occasion and the other a matter of principle regarding staff training. In the particular circumstances pertaining to the man's death, the delay between the man being laid on the floor in the recovery position and the initiation of CPR by a nurse could be measured in seconds and would not have materially altered the outcome. In principle, however, it is desirable that all prison officers should be competent in basic life support techniques and therefore able to initiate CPR.

RECOMMENDATIONS

I make the following recommendations arising from this investigation:

To the Prison Service

The work underway by Safer Custody Group to investigate the provision of safer bedding should be expedited to reduce the likelihood of torn sheets being used to make a noose.

Consideration should be given to equipping all prison officers with the necessary training to initiate CPR.

To the Governor

The local policy on suicide prevention should be reviewed and revised to ensure that the instruction 'requiring constant company' is understood by staff. Its application in relation to level two and three observations should be explained, and how it should be considered and recorded should be clarified.

Consideration should be given to providing a training event for staff, particularly reception officers and nurses who undertake initial health screening. The purpose of the training would be to learn from the case of The man with respect to probing for information and critically appraising prisoners' self reporting of their state of mind.

The local agreement with the emergency services should be reviewed to ensure that there is a clear written form of recognition that life is extinct or certification of death before the removal of a body.

Consideration should be given to reviewing the number of safer cells to ensure the provision of ligature free cells is sufficient to meet the identified local need.

Consideration should be given to requiring wing managers to provide a named member of staff to monitor each prisoner on F2052SH monitoring.

Wherever possible, the next of kin should be visited by a senior member of staff from the prison to break the news of the death, rather than relying on local police to undertake this role. Prison staff are more likely to be able to provide informed answers to relatives' initial questions, which may bring comfort and reduce distress.