Investigation into the circumstances surrounding the death of a prisoner at HMP Nottingham in June 2004

Report by the Prisons and Probation Ombudsman for England and Wales

November 2004

CONTENTS

PART ONE

		Page
1.	Foreword	3
2.	Summary	6
3.	Report by Senior Investigating Officer	8

PART TWO

Supporting documentation

FOREWORD

This is the report of an investigation into the circumstances surrounding the death of a prisoner at HMP Nottingham in June 2004.

The investigation was conducted under the terms of the transitional arrangements agreed between my office and the Prison Service, which came into effect on 1 April 2004. The bulk of the investigative work has been conducted on my behalf by a member of the senior management team from the East Midlands North Area Office. She was assisted by a second member from the East Midlands North Area Office, and a member of staff from HMP Lincoln. An independent clinical review was conducted and also an assessment on the clinical management of the man's drug dependence was conducted by Prison Health. I am enormously grateful to all members of the team for their thorough and diligent work.

I have structured this report so that the senior manager's investigation can be separately identified.

The senior manager twice visited the man's mother at her home during the course of the investigation. A doctor accompanied her on the second of these visits. In addition, she had spoken to the man's mother on the phone frequently in order to update her on the progress of the investigation. I know she has offered her sympathy and condolences, but I would like to take this opportunity to add my sincere condolences to the man's mother, family and friends.

A colleague from my office liaised with the senior investigating officer throughout this investigation. I personally also visited HMP Nottingham when the investigation commenced.

I should record here my thanks to the former governing Governor, the Governor, and their staff for the help and hospitality the investigators received during the investigation. Every assistance was made available and all staff co-operated fully and readily with the inquiry.

The man's death was the 23rd apparently self-inflicted death to have occurred at Nottingham in the last ten years, and the seventh since the beginning of 2003. I was interested, therefore, to read the comments in the excellent Annual Report of the prison's Independent Monitoring Board, published in May this year. This notes that, "Nottingham prison draws prisoners from an area where the incidence of suicide is higher than the national average." The Report argues that higher priority should be given to suicide and self-harm training - a recommendation echoed in this investigation - while praising the staff and prison response to any death in custody (again, something which emerges well here).

I also looked at the (unpublished) report of a Prison Service-sponsored panel that reviewed the series of deaths that took place at Nottingham in 2001-02. I

note the comment that Nottingham's "reception area … [is] not fit for purpose." Again this chimes with a recommendation of this investigation. Indeed, when I visited reception with the senior investigating officer I found it to be in a grim and depressing state - both in terms of décor and procedures. The panel report also criticised the state of the Heathcare centre.

However, when I re-visited Nottingham just a month after the man's death I found that reception had been re-painted and deep cleaned and that the Healthcare centre had been closed for refurbishment and the installation of in-cell electricity. The then Governor's report to the IMB for June 2004 records:

> "The Governor was keen to put into place any learning from the death of the man who is the subject of this report. In response to issues raised by the Prisons Ombudsman, the following work is being completed: Reception Holding Cells have been repainted; Reception is being deep-cleaned later this week; a bid has been put forward to the Area Manager to improve the environment on B Wing including painting of all cells and the wing area; the Healthcare department will be closed for a period of three weeks … to install in-cell TV and electrics. This has been brought forward in the original programme and is being supported by the Area Manager. The new Reception Screening Process has been implemented. In addition we have relocated the Treatment Room on B Wing to the First Night Centre."

By any standard, this is an impressive and immediate response to the tragedy of the man's death and the prison should be strongly commended for it.

Nevertheless, these actions will provide scant comfort for his family and friends. As his medical records show, the man who died was a deeply troubled person. The Primary Care Mental Health Assessment noted he was a "prolific self-harmer - injected noxious substances in past." A further section referred to the man's hearing voices and quotes him as saying he would "do anything to kill himself when they get to me". The man said he was a daily user of heroin. (He was also a 20 a day smoker, but was out of tobacco on the day he died.)

Those people with a dual diagnosis of mental illness and drug abuse present a major challenge to healthcare professionals - whether in prison or on the outside. Indeed, an entry dated 9 June on his Inmate Medical Record makes exactly that point:

> "Will find combination of detox and currently untreated mental illness very difficult. Denies current suicidal ideation though consider 2052 should assertions/presentation change."

In the event, it seems that the man simply did find this combination impossible to bear.

It would appear that a principal reason for him being remanded into custody was his record of twice previously having failed to surrender to bail. Given

this, and the nature of the charges he faced, it is not difficult to understand why the magistrates declined to offer bail again. However, the sad circumstances of his death raise the question of whether any prison could provide the combination of care and treatment that he so demonstrably required.

STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN

SUMMARY

This is the report of an investigation into the death of a prisoner at HMP Nottingham in June 2004.

The man who died was remanded into custody on 8 June on charges of harassment. This was the first time he had been in prison custody.

During the reception process the man was identified as a poly drug abuser requiring a detoxification programme. He was noted to have received care and treatment associated with mental health issues. He also disclosed to staff that he had previously self-harmed but at that point did not feel like self-harming.

The man was initially located on the Induction Unit but on 9 June was transferred to the in-patient unit of the health-care unit to enable management of his withdrawal from drugs and mental health needs.

On the morning he died, the man complained to the doctor and nurse that he was "troubled" and complained of increased voices, although he denied they were telling him to hurt himself or others.

He collected his lunch later that morning and returned to his cell for the patrol period. Shortly after lunch he was found by the prisoner orderly to be sitting on the floor with shoelaces tied around his neck. The orderly summoned help.

The man who died had a long history of mental illness, drug abuse and self-harm and whilst he did not indicate that he had any suicidal ideation, he was alone in a cell for the first time, with no television or radio, just the voices in his head.

This report makes six recommendations:-

> Prisoners withdrawing from drugs should share a cell with another prisoner where possible.
>
> Prisoners withdrawing from drugs should not be located in cells with bunk beds.
>
> All prisoners should be offered the use of a radio in cell where there is no provision for televisions.
>
> A review of instructions and procedures to keep prisoners safe on the healthcare centre should be carried out to ensure that Orders are carried out effectively.

A review should be carried out of the frequency of training in suicide prevention measures at Nottingham and a plan of action drawn up to address the short-fall in provision of training.

The Governor of Nottingham should urgently review the experience of Reception for prisoners and make changes to ensure that privacy, safety, dignity and reassurance are the priorities of the Reception process.

Senior Investigating Officer's report, prepared by a senior manager at the East Midlands North Area Office

CONTENTS

Section		Pages
1.	Executive Summary	9
2.	Investigation	14
4.	Timeline – the man's movements after arrest	16
5.	Reception into Nottingham Prison	20
6.	B1 – First night in custody	21
7.	D4 – Drug detoxification unit	22
8.	Healthcare Centre	23
9.	The man's medical management	24
10.	Shoe laces	25
11.	The cell call system	26
12.	Discovery of the man's death	27
13.	Staff response / resuscitation	28
14.	Post incident response	29
15.	The experience of the mans's family	30
16.	Nottingham's Suicide Prevention strategy	31
17.	Conclusions	32
18.	Recommendations	34
19.	Good Practice	35

1. EXECUTIVE SUMMARY

1.1 This is a report of the inquiry into the circumstances surrounding the death of a prisoner at Nottingham prison in June 2004.

1.2 He was arrested at Derbyshire Divisional Police Headquarters at 0150hrs on Tuesday 8 June on an outstanding warrant for twice failing to surrender to bail on charges of harassment. He spent the night in police custody at Wyatt's Way police station at Ripley and was taken to Derby Magistrates Court later that morning.

1.3 At 1607hrs on 8 June, the man was produced before the court where he was remanded in custody until 16 June. The reasons given by Magistrates were that he had failed to surrender to custody twice, he had a previous poor bail record and the "character / antecedents of the accused".

1.4 He was received at Nottingham prison at 1800hrs. This was his first time in custody. He went through the prison's Reception process and was then taken to B1 unit, the First Night in Custody centre.

1.5 On B1, the man was given an initial Induction interview in which it was established that he could read and write and that he required a detoxification programme, because he was a drug user.

1.6 A Healthcare Officer interviewed the man to complete his First Reception Health Screen. He told her that he used Heroin, Amphetamines and Benzodiazepines and that he suffered with Schizophrenia. He had in the past been a voluntary in-patient on a psychiatric ward at Derby City hospital. He had been prescribed medication for his mental health problems, but did not use it because it didn't work. He found Heroin more effective in calming the voices in his head.

1.7 He disclosed that he had self-harmed in the past but said that he did not feel like self-harming at that point.

1.8 He was seen by the Detox nurse and was prescribed Buscopan to help with stomach cramps and Brufen for back pain – both symptoms associated with drug withdrawal.

1.9 The man was placed in a double cell with another prisoner and spent an uneventful night on B1.

1.20 On the morning of 9 June, he completed his induction to the prison and was then moved to D4 – the Drug Detoxification Unit. The detox nurse was concerned that the man had mental health problems and asked for him to be assessed by a mental health nurse. An RMN carried out a joint primary and secondary mental health assessment. She was concerned that the man would find the combination of

withdrawing from drugs and mental ill-health very difficult, so made the decision that he should be admitted to the prison Healthcare unit, where he could be more closely observed. She noted that he had no suicidal ideation at that time.

1.21 On the evening of 9 June the man was transferred to the in-patient department of the healthcare centre. He was located in a double cell, H1.09, with another prisoner. It is recorded in his Inmate Medical Record (IMR) that he spent a settled evening resting on his bed, that he made no requests and that no odd behaviour was observed. He was awake at 0500hrs the next morning complaining of back pain. He was given paracetamol.

1.22 On 10 June, the man spent his first full day on the Healthcare centre. He saw Nottingham's part-time GP. The Doctor noted the man's history of drug use, previous self-harm, the fact that he had been troubled with voices for more than 10 years and that he was not currently prescribed anti-psychotic medication. He also noted, "Denies current DSH (deliberate self-harm) ideation".

1.23 There are several other entries in the man's IMR for 10 June relating to him being given medication for back pain and symptoms associated with drug withdrawal. One entry notes, "Also appears distracted….no expression of wish to self-harm", another, "not expressing any concerns".

1.24 A number of prisoners had contact with him on the day before he died, Including his cell-mate and two healthcare orderlies.

1.25 The man's cell mate alleged that one of the orderlies had told the man who died that he would be beaten up when he went to ordinary location because of the nature of his charge. We have found no evidence to substantiate this .

1.25.1 An OSG was on the Healthcare unit the day before the man died when he overheard the two orderlies offering to buy PIN phone credits from the man and his cellmate, in exchange for tobacco. The offer was turned down and later that day the man complained that the paper with his PIN phone code on it had gone missing from his cell. However, it was later found amongst his effects and records show that the only call on his account was a call made to his mother on 10 June. The OSG said that the tone of the conversation between the prisoners was not coercive and there is no evidence that the man felt threatened in any way.

1.25.2 The man's call to his mother revealed that he was feeling "rough" and that he was hoping that his next court appearance would "get things sorted". The tone of the conversation was pleasant and supportive.

1.25.3 The man was out on association with other prisoners that day and was

offered a haircut by the orderlies, which he declined.

1.26 His IMR records that he again asked for painkillers for his back in the early hours of the day he died, but that he had slept well.

1.27 On the morning of the day he died, his cell mate was moved from the Healthcare Centre on to normal location, leaving him in cell H1.09 alone. Patients were unlocked and free to associate on the Ward that morning.

1.27.1 At about 10am the man saw the doctor and a nurse. The doctor noted that the man was "troubled" and complained of increased voices. The nurse asked him if the voices were telling him to harm himself or anyone else. He denied this. He requested something to calm him down. The doctor prescribed Chlorpromazine, an anti psychotic drug with a calming effect. The drug was administered to the man by the nurse, at about 1030hrs and would have had some effect within about an hour. The nurse remembers that it was a particularly calm and cheerful atmosphere on the Ward that morning and that she joked with the man about the dye in his hair and gave him a couple of cigarettes and some chocolate.

1.27.2 At about 1130hrs the man collected his lunch from the servery and took it back to his cell to eat. He should have taken off his training shoes and left them outside his cell. All prisoners wearing footwear with laces were required to leave them outside when they were in their cells. On this occasion he did not, and staff did not notice that he had not.

1.28 The last person to see the man alive was another nurse. She looked into his cell between 1315 and 1325hrs. She said that he was sitting on his bed (the lower of two bunk-beds) that he seemed calm and that he acknowledged her with a smile, although they did not speak.

1.29 At about 1345hrs, a prisoner orderly arrived on the Ward and began to collect lunch trays from prisoners' cells. This is accomplished by the tray being handed through a hatch in the cell door. He recalls calling for the man's tray outside the cell and, receiving no response, moving on to the next cell. He went back to the man's cell a minute later and looked through the hatch. He saw the man sitting on the floor at the end of the bunk beds, with shoe laces tied around his neck and attached to the metal frame of the bed. Realising that something was wrong, he called for staff assistance.

1.30 The first nurse and the Healthcare Principal Officer entered the man's cell, released him from the ligature and attempted to resuscitate him. Paramedics were on the scene within 15 minutes of being called. Sadly, all attempts to save his life were in vain and a doctor pronounced his death at 1445hrs.

1.30.1 The man who died had a long history of mental illness, drug abuse and self-harm. It is likely that the experience of being in custody for the first time, withdrawing from drugs and the effects of mental illness were too much for him to cope with. It is significant that the report prepared by the Prison Health Detoxification Advisor highlights that one of the effects of Amphetamine withdrawal can be sudden and profound drops in mood. There is no effective medication to treat symptoms of Amphetamine withdrawal.

1.31 It may also be significant that, although he had shown no suicidal ideation throughout his time in the prison, he died when he was locked in a cell alone for the first time, with no television or radio, just as the voices inside his head were increasing.

1.38 This report makes six recommendations and offers one example of good practice.

2. INVESTIGATION

2.1 The staff officer to the Area Manager for East Midlands North was appointed to conduct the inquiry on behalf of the Ombudsman.

2.2 The senior manager, my investigator and the ombudsman visited HMP Nottingham, where we received a briefing from the Governor ahead of visiting the cell and meeting members of the local Prison Officers' Association branch committee.

2.3 We issued a notice to prisoners and staff, inviting anyone who might have information relating to the man's death to make themselves known to the inquiry.

2.4 We interviewed prison staff and prisoners who worked and lived on the Healthcare unit. We were given access to statements given to police and furnished with a copy of the Post Mortem and Toxicology reports.

2.5 We held two meetings with members of the man's family. They were extremely helpful in giving us background details of his life and medical issues.

2.6 A separate Clinical Review of the man's medical treatment in prison was carried out.

2.7 A review of Nottingham prison's arrangements for detoxifying prisoners using drugs was carried out by Prison Health.

2.8 We examined various documents relating to the man's time in prison. They are listed at Appendix 3.

2.9 The inquiry team received all due co-operation and assistance from prison staff and prisoners, police and medical practitioners.

4. TIMELINE – THE MAN'S MOVEMENTS AFTER ARREST

Date / Time	Event
Tuesday 8 June	
0150hrs	Arrested by police on a warrant for failing to appear at court.
0155hrs	Arrives at police station. Is searched and found to be in possession of a substance believed to be class A drugs. Told police he was not currently taking medication and was depressed.
0311hrs	Observed to be sleeping.
0615hrs	Saw Police Surgeon.
0744hrs	Spoke to duty solicitor by telephone.
0803hrs	He was given breakfast and complained that the doctor had not left him any medication.
0846hrs	Interviewed re the substance found in his possession.
0905hrs	Collected from the police station by Group 4.
0950hrs	Arrived at Magistrates court.
1135hrs	Legal visit.
1607hrs	Before Magistrates in court 8. Remanded in custody until 16 June.
1800hrs	Received into Nottingham prison. He went through the Reception process before going to the First Night Centre.
1853hrs	Received on to the First Night Centre. The man was given an initial Induction interview where it was noted that he was "detoxing" and that he could read and write. He received a Reception health screen where he reported the level and range of his drug use and that he was not currently receiving medication for Schizophrenia. He told staff about previous self-harm attempts and said that he did not feel like harming himself at that time. Staff carried out a cell-sharing risk assessment and he was placed in a cell with another prisoner for the night.

	The man would have been given something to eat and drink, a tea pack containing tea, coffee, milk and sugar and would have been locked in his cell at about 2000hrs.
<u>Wednesday 9 June</u>	
a.m.	Whilst on B1 (FNC) he was given the first dose of Lofexedine to treat drug withdrawal symptoms. He was also given Ibuprofen after complaining of back pain.
1119hrs	He was received on to D4 landing, the drug detoxification unit.
p.m.	The detox nurse on D4 was concerned about the man's behaviour and asked that he be examined by a mental health nurse. An RMN saw him mid-afternoon. She found the man's behaviour to be "chaotic" but was unsure whether it was a result of drug induced psychosis or schizophrenia. She was concerned that he would find the combination of withdrawing from drugs and mental ill-health very difficult and so decided that he should be admitted to the prison's Healthcare unit. A nurse completed a joint primary and secondary mental health assessment and reported that he was showing no suicidal ideation at that time.
1927hrs	The man was admitted to the Healthcare centre and co-located in a double cell.
<u>Thursday 10 June</u>	
0500hrs	The man was given a painkiller for back pain. The night nurse reported that he slept well and did not demonstrate any odd behaviour.
a.m.	Seen by a doctor, he noted that the man reported that he was not feeling suicidal, was eating well and his sleep was "variable". The man was not on any anti-psychotic medication and had experienced voices in his head for more than 10 years, which did not change with prescribed medication. The doctor noted that the plan was that the man should continue with the detox regime.

1000hrs	He complained of back pain and was given 400mg Brufen.
1420hrs	The man continued to experience detoxification symptoms. He appeared "distracted" but expressed no intention to self-harm. He spent the majority of the day laying on his bed.
1900hrs	Again given Brufen for back pain. Staff reported that there was little communication from him, but that he said that he was hungry and was given extra milk. He was not expressing any concerns.
<u>Friday 11 June</u>	
0600hrs	The night nurse gave the man paracetamol because he was complaining of back pain. He had slept well.
a.m.	He saw the doctor. He complained that the voices had increased. He was troubled and asked for "something to calm me down". The doctor prescribed Chlorpromazine (an anti-psychotic drug) and recommended a review by a psychiatric nurse "ASAP".
a.m.	The man's cell-mate was moved to D4 unit.
1100hrs	A nurse reported that the man had spent a "quiet morning" and was "interacting well with peers and staff". He had been given a dose of Chlorpromazine and was continuing with detoxification medication.
1115 – 1130 hrs	The man approached the staff office and asked if he could have some numbers added to his PIN phone list. A nurse spoke to him and asked him if he was okay. He replied "Good miss, I'm okay". He collected his lunch from the servery and returned to his cell to eat it. He was locked in for the staff lunch-break period.
1330 – 1345 hrs	Another nurse saw the man sitting on his bed. She did not speak to him but says that he "appeared calm and under no duress".
1355hrs	A Prisoner Orderly went to the man's cell to collect his lunch tray. On looking through the open observation hatch, he saw the man sitting on the floor with a ligature, made from training shoe laces, around his neck. The Orderly called for staff assistance. A nurse arrived at the scene and called for more

	staff. She entered the cell with the Healthcare Principal Officer. They cut the man free and began attempts to resuscitate him. The prison Communications officer called for an ambulance.
1405hrs	Paramedics arrived on the scene and continued resuscitation attempts.
1445hrs	A Prison Medical Officer pronounced the man dead.

5. RECEPTION INTO NOTTINGHAM PRISON

5.1.1 The man arrived at Nottingham prison at 1800hrs on Tuesday 8 June. Up until 1800hrs each evening, prisoners are seen for the First Reception Health Screen in the Reception area. After 1800hrs, new prisoners go through the process of being searched and having their personal details, finger prints and photographs taken in reception. All other processes, including the First Reception Health Screen are carried out on B1 Unit. This was the case with the man who died.

5.2 The Reception process at Nottingham requires that new prisoners stand at a table to give their personal details to staff. This interview is carried out in the full hearing of others present, be they staff or prisoner orderlies. This leaves the prisoner vulnerable, because other prisoners have knowledge of their personal circumstances and the nature of their charge.

5.3 The prisoner is then taken into a room with two other staff and required to remove his clothes for a strip search. Although no one outside the room can observe the process, there is no privacy screen within the room and anyone entering can immediately see the prisoner undressed. Prisoners new to the experience of custody can only find this intimidating.

5.4 After the strip-search, the prisoner is given a dressing gown to wear and a set of prison clothes. He is put in to a holding room to get changed, which he may have to do in front of other prisoners.

5.5 On the day that we visited Nottingham prison, the holding rooms in Reception were in an extremely shabby state, with abusive graffiti covering the walls and some burned into the ceiling with cigarette lighters. We drew this to the attention of the Governor and understand that this was rectified soon after our visit, but it can only have been an unwelcoming and intimidating experience to a person new to prison custody.

5.6 In addition to the above, we learned from staff that prisoners are not offered a cup of tea on arrival. We understand that the imperative is to move prisoners through Reception quickly because it is a very small and cramped area which has to cater for a large number of prisoners entering and leaving the prison on a daily basis. However, we feel that there is much that can be done to make the process a more humane and decent experience.

6. B1 – FIRST NIGHT IN CUSTODY

6.1 On B1 the man went through the initial Induction process where he was informed of the services available to him and policies on matters such as Race Relations and Anti-Bullying were explained to him. It was noted that he could read and write and that he was in need of detoxification.

6.2 A Healthcare Officer carried out a First Reception Health Screen and conducted a Cell Sharing Risk Assessment, which indicated that the man was suitable to share a cell with another prisoner.

6.3 Documentation found in his cell on the Healthcare centre showed that he had been made aware that he had access to Samaritans trained “Listeners” in the prison, should he need their services.

6.4 The man was placed in a cell with another prisoner and spent an uneventful night.

7. D4 – DRUG DETOXIFICATION UNIT

7.1.1 The man spent only a couple of hours on the Detox unit. The Detox nurse was concerned that he was struggling with mental health problems and asked that he be assessed by a Registered Mental Health Nurse. This took place a couple of hours after his arrival on D4, and he was transferred to the Healthcare Centre on the evening of 9 June.

8. HEALTHCARE CENTRE

8.1 Nottingham's Healthcare centre is located on the ground floor of C wing. There are eleven cells, one being a "gated" cell for observing the most vulnerable prisoners and one being a double cell, accommodating two prisoners.

8.2 The department is staffed by a mixture of NHS nurses and prison Healthcare staff, some of whom are trained nurses. The department is currently in a transitional period, which will result eventually in all medical and nursing services at Nottingham being commissioned and delivered by the local Primary Care Trust.

8.3.1 At the time of the man's death there was no in-cell electricity to any of the cells. This meant that prisoners did not have access to in-cell television, but could watch the television in the association room when they were unlocked (unlock times in the Healthcare Centre average six hours per weekday and eight hours per day at weekends. In the rest of the prison they average seven and a half hours per weekday and just over three hours per weekend day.) There were also facilities to play pool or listen to music in the association room. He did not have a radio in his cell.

8.4 The double cell in which the man was located was furnished with bunk beds. He attached the ligature with which he hanged himself to the metal frame of the bed. The man's cell mate was also detoxing, from alcohol. There may be distinct benefits if two detoxing prisoners share a double cell. However, there may be distinct dangers if prisoners going through the detoxification process have bunk beds. I understand the operational challenges this poses in a busy local prison. However, bunk beds do present a risk, not only from self-harm, but also because withdrawal from drugs or alcohol can affect balance and co ordination and can therefore lead to accidents.

8.5 I understand why the Prison Service could not immediately or universally effect a policy whereby detoxing prisoners do not share cells equipped with bunk beds. However, I believe this represents a situation to which the Service should aspire.

8.6 The decoration of his cell was shabby and there was nothing in the cell to provide activity for the occupants. In the absence of television it would have been good practice to supply a radio.

9. THE MAN'S MEDICAL MANAGEMENT

9.1 A doctors review of the man's clinical management is at Appendix 7. He concluded that, "Healthcare staff involved in the care of the man who died acted compassionately and appropriately, in keeping with the expected professional standards. They had a care plan which they did their best to implement".

9.2 The man's Inmate Medical Record shows that, from his arrival on the Healthcare Centre, his condition was closely monitored and his propensity to self-harm or possible suicidal ideation was constantly under review. He was cared for by doctors and general and mental health nurses. All were consistent in their view that he showed no sign of being suicidal.

9.3 We asked specific questions about the management of the man as a person with the dual problems of drug addiction and Schizophrenia. We asked the question, why was he not given anti-psychotic medication immediately on his arrival at the prison, when he clearly told staff that the voices in his head became worse when he did not have Heroin? The doctor explained that it is impossible to assess the extent of mental illness whilst a person is under the influence of opiates and, therefore, he needed to go through the process of detoxification before he could be properly assessed.

9.4 There is no evidence to suggest that the man received anything less than appropriate care, observation and treatment from Healthcare staff.

10. SHOE LACES

10.1 At the time of the man's death there was an extant Governor's Order (4/04, Appendix 11) which stated that, on admission to the Healthcare Centre, all prisoners were to have any shoe laces removed from their shoes and that they should be issued with slippers to wear in-cell. This Order was a result of an action plan drawn up into a previous death in custody at Nottingham prison. All staff interviewed were aware of this.

10.2 There was no instruction in place as to how staff should ensure that shoelaces were not taken in to cells. Staff were rightly reluctant to ask prisoners to wear shoes without laces – this would be as potentially dangerous as it would be demeaning. The understanding was that prisoners would leave their shoes outside of their cells and would wear slippers when in-cell. However, some prisoners arrived on the ward already wearing slippers or slip-on shoes. This meant that an absence of shoes outside a cell did not necessarily mean that a prisoner was in possession of laces. Staff told us that they would usually check to see if a prisoner had shoes with laces during routine observations. Clearly, on the day of his death, this did not happen. We understand that all prisoners on the Ward are now issued with slip-on shoes.

10.3 It is important to note that there were other items in the man's cell that he could have used to make a ligature, e.g. bed sheets.

11. THE CELL CALL SYSTEM

11.1 A member of staff and a prisoner on the Ward raised concerns about the practice of muting the buzzer which indicated that a prisoner had pressed his cell call bell for assistance. At the time of the man's death, there was in place a protocol (Appendix 12), which allowed the buzzer to be muted in certain circumstances and with particular authority. All nursing and Healthcare staff interviewed were aware of this protocol and could describe how it should work.

11.2 There is no evidence that the buzzer had been muted on the day he died.

11.3 The Healthcare centre has been subject to a planned refurbishment since the man's death and it is no longer possible to mute the buzzer.

12. DISCOVERY OF THE MAN'S DEATH

12.1 The man was located in cell H1.09. There were three other prisoners on the Ward that day, one in cell 8 next to him, one in cell 11 and one in the gated cell, number 6 (see map at Appendix 13).

12.2 All hatches to the cells were lowered during the lunch time period (from 1215hrs – 1345hrs). The prisoner in the gated cell was on constant watch (a member of staff permanently outside his cell).

12.3 Two members of staff were detailed to observe patients throughout the lunchtime period. This was carried out by frequent, irregular checks at no more than 30-minute intervals. Checks on prisoners not on a formal watch are not recorded.

12.4 One prisoner stated that he heard the man call for staff over the lunchtime period. A prisoner in a cell closer to his did not hear this. Several members of staff were on the Ward, eating lunch and socialising in the prisoner association room. If the man had called out, they were only a few feet away from him.

12.5 The prison orderly discovered the man's body at 1355hrs. Healthcare staff were on the scene and in his cell seconds later. The Communications Officer's log notes that an ambulance was called at 1357hrs. The ambulance arrived at 1405hrs and paramedics were on the scene immediately.

13. STAFF RESPONSE / RESUSCITATION

13.1 On entering the man's cell, a principal officer attempted to remove the ligature but could not because the shoelaces were pulled too tightly on the man's neck. He used a ligature knife to cut the laces and laid the man on the floor, where he removed them.

13.2 The PO began mouth-to-mouth resuscitation whilst a nurse started chest compressions. Within a few minutes another nurse arrived with a defibulator, which checked for electrical impulses in his body. The machine instructed staff not to shock the man's heart. (The machine measures electrical impulses coming from the body. The impulses have to be recorded at a certain level for the machine to advise shocking. The fact that it told those attempting to resuscitate him not to shock would mean that he was already dead and that there was no point in attempting to shock him.) Staff continued to try to resuscitate the man.

13.3 Paramedics were on the scene at 1405hrs and continued resuscitation attempts.

13.4 Whilst this was on-going a number of Healthcare and discipline staff were engaged in managing the scene outside the man's cell. Other prisoners on the Ward were supported by staff. One prisoner did make the point that he would have appreciated being put in a cell with another prisoner for support at that stage.

13.5 The Orderly Officer and Duty Governor attended the scene to co-ordinate the incident and ensure that all proper contacts were made.

13.6 The prison Medical Officer was called and pronounced the man's death at 1445hrs.

14. POST INCIDENT RESPONSE

14.1 Police attended the scene and a Scenes of Crime Officer carried out an inspection of the man's cell. The SOCO took photographs and a video recording of the cell with his body in place.

14.1.1 The man's body was removed from the prison at 1748hrs and the cell was sealed.

14.2 A hot de-brief was carried out and staff involved in the incident were allowed to recount their experience and were offered support.

14.3 Prisoners working and living on the Healthcare centre at the time of the man's death have told us that they were very well looked after and offered appropriate support.

14.4 All necessary agencies were informed of his death.

15. THE EXPERIENCE OF THE MAN'S FAMILY

15.1 The man's mother was notified of his death by the Governor and Principal Officer at her home at 1730hrs on 11 June.

15.2 She and her family declined an offer to visit her son's cell.

15.3 We wrote to the man's mother telling her of this Inquiry and offering the opportunity to the family to contribute to it. The senior manager twice visited the man's mother and her family at her home, on the second occasion in the company of the doctor reviewing the clinical enquiry. The senior manager has also been in frequent touch with the man's mother by telephone. The information given by the family in respect of the man's life has been invaluable to the Inquiry team.

15.4 The man's mother had particular questions around his medical treatment. These included how the man was managed in relation to his heroin detoxification; how he was managed as a person suffering the symptoms of schizophrenia and if the dual effects of these problems were adequately considered when decisions were made about how to treat and medicate him. Furthermore, she was keen to know if the healthcare department did all they could in obtaining information about her son's medical history and needs from the agencies that had cared for him in the community. We hope the questions have been answered by this inquiry and the Clinical Review.

15.5 The family also wanted to know why the man was left in possession of his shoelaces. The fact is, he should not have been and staff did not adhere to the Governor's Order. This was clearly an oversight. However, he would have had access to other materials with which to make a ligature in his cell.

15.6 The man's family asked how he could have had the opportunity to kill himself whilst in prison. He was not considered at risk of self-harm or suicide at the time and therefore would not have been subject to special monitoring arrangements. He was frequently and regularly observed; however, the Post Mortem report indicates that the time from him putting the ligature around his neck to falling unconscious and dying would have been only a few minutes.

15.7 The Governor has acted as Liaison Officer to the family. I know that the man's mother in particular is very grateful for the support and assistance he has offered. He has carried out his role in an exemplary manner.

16. NOTTINGHAM'S SUICIDE PREVENTION STRATEGY

16.1 The Inquiry team examined several sets of minutes from the monthly Suicide Prevention Team meeting. The Suicide Prevention Team looks at:

1. Reviewing and developing local policy and procedural instructions
2. Carrying out reviews of incidents of suicide and self-harm
3. Maintaining staff and prisoner awareness of suicide prevention issues
4. Identifying training needs and monitoring delivery
5. Monitoring the quality of F2052SH procedures
6. Management and review of individual cases
7. Supporting the prisoner Listener scheme and ensuring it is operated effectively, as agreed with the Samaritans
8. Overseeing the implementation of action plans from previous deaths in custody.

16.2 The meeting is chaired by a senior governor and is attended by all functional areas within the prison. Its membership also includes prisoner Listeners and the Samaritans.

16.3 The last Standards Audit, conducted in October 2003 resulted in a "good" rating in Suicide Prevention. (There were two baselines that rated "less than good". They were 60.10 - Saturday receptions not always seen by a doctor within 24 hours, and 60.19 - not all deliberate self-harm incidents logged via the Incident Reporting System.)

16.4 We were concerned that, of all the staff interviewed, none had received any training in suicide prevention in the past two years. They did however demonstrate a good understanding of suicide prevention policy and F2052SH procedures. It was particularly encouraging that one of the prisoner orderlies (not a trained Listener) could describe very accurately what should be done if he suspected that a prisoner was in danger of self-harming.

16.5 Nottingham has a full-time Suicide Prevention Co-ordinator. She is committed and knowledgeable.

17. CONCLUSIONS

17.1 The man's needs and vulnerabilities were promptly and accurately identified within hours of his reception into Nottingham prison. Staff did the very best they could to offer appropriate care and treatment.

17.2 He gave no indication to staff or to prisoners that he intended to take his own life.

17.3 The standard of documentation in the man's medical record was good. Referrals had been made appropriately and promptly and every effort was made to access information about the his medical history in the community.

17.4 It could be argued that, having disclosed previous episodes of self-harm and being known to be suffering from mental illness and drug withdrawal, the man should have been placed on a F2052SH (self-harm at risk form). However, he was regularly monitored and assessed by Healthcare and medical staff who were looking specifically for evidence that he intended to harm himself. They found none. If he had been placed on a F2052SH as a precautionary measure, it is unlikely that the recommendation would have been to monitor him at more than 30- minute intervals. He received this level of monitoring on the Healthcare centre as a matter of course.

17.5 Staff interviewed during the course of the Inquiry had not received training in suicide prevention measures for at least two years. This is a cause for concern and should be rectified.

17.6 Staff on the Healthcare centre failed to remove the man's shoelaces as required by the Governor's Order. There was no clear instruction to staff on how the removal of shoes with laces should be monitored.

17.7 It is likely that, if the man were determined to kill himself, he would have found other material in the cell with which to construct a ligature.

17.8 There is no evidence that the man was the victim of bullying or intimidation from other prisoners.

17.9 The man took his life within a couple of hours of being locked in a cell alone for the first time. It may be that, if he had access to a radio or television in his cell, it could have distracted him from the voices in his head and provided company to replace that lost when his cellmate moved out.

17.10 Prisoners undergoing detoxification should share a cell unless the cell sharing risk assessment indicates otherwise.

17.11 It is not good practice to place prisoners withdrawing from drugs in a cell with bunk beds. They offer easy ligature points and are otherwise not suitable for people with balance and co-ordination difficulties.

17.12 Although it has no direct bearing on the man's death, conditions and processes in the prison's Reception are demeaning and likely to intimidate new prisoners, particularly those committed to custody for the first time.

17.13 After finding the man, staff acted promptly and professionally and made every effort to resuscitate him. It is worthy of note that, because there is a protocol in place between the prison and Nottingham Ambulance Service, paramedics were with the man within 15 minutes of the ambulance being called.

17.14 The level of care extended by managers at the prison to the man's family has been exemplary. They have tried as far as possible to meet their needs for information and practical assistance.

17.15 Nottingham's contingency plans were good and were followed appropriately.

17.16 Staff and prisoners were appropriately supported in the aftermath of the man's death.

18. RECOMMENDATIONS

18.1 Prisoners withdrawing from drugs should share a cell with another prisoner where possible.

18.2 Prisoners withdrawing from drugs should not be located in cells with bunk beds.

18.3 All prisoners should be offered the use of a radio in cell where there is no provision for televisions.

18.4 A review of instructions and procedures to keep prisoners safe on the Healthcare centre should be carried out to ensure that Orders are carried out effectively.

18.5 A review should be carried out of the frequency of training in suicide prevention measures at Nottingham and a plan of action drawn up to address the short-fall in provision of training.

18.6 The Governor of Nottingham should urgently review the experience of Reception for prisoners and make changes to ensure that privacy, safety, dignity and reassurance are the priorities of the Reception process.

19. GOOD PRACTICE

19.1 The Governor carried out his difficult duties as the family liaison officer in an exemplary manner. The decision personally to visit the man's mother to break the sad news of the man's death is an example of good practice.