INVESTIGATION INTO THE CIRCUMSTANCES OF THE DEATH OF A MAN AT HMP MANCHESTER IN JUNE 2004

PRISONS AND PROBATION OMBUDSMAN
FOR ENGLAND AND WALES
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This is the report of an investigation into the circumstances of the death of a man who died by hanging in his cell on the detoxification wing at HMP Manchester in June 2004. The police are satisfied that no one else was involved and that his death was self-inflicted.

The man was a member of a loving family who had wrestled with how best to help him overcome his dependence on heroin. In one of his last letters he wrote of another addicted prisoner,

> "He's in here for one theft from a shop and because he has nowhere to live. Take the nasty away and we're good people. With it you do stupid things to support the habit."

I offer my deepest sympathy to the man's parents and his brother and sister.

The investigation has been conducted on my behalf by an investigator, in conjunction with one of my Assistant Ombudsman. A doctor conducted a clinical review on behalf of the North Manchester Primary Care Trust.

I am grateful to the Governor and staff of HM Prison Manchester for their co-operation and assistance with the investigation.

Stephen Shaw CBE — June 2005
Prisons and Probation Ombudsman

CONTENTS

SUMMARY

1. On Friday 18 June 2004, at Trafford Magistrates' Court, the man pleaded guilty to theft, said to be of a bottle of whisky. He did not apply for bail and was remanded in custody.

2. On Monday 21 June, at about 7.15am, the other occupant of Cell 3.8 in H Wing awoke to find the man, who would have been 30 years old the following day, hanging by a tracksuit cord ligature from the end of the bunk bed. He pressed the cell call bell and alerted staff.

3. Officers responded and unlocked the cell. A senior officer checked for vital signs and took the view that the man was dead and had been for some time. His view was confirmed at about 7.20am by a nurse. After a short delay, the senior officer supported the body and an officer cut the ligature. No CPR was attempted and it was 30 minutes before an ambulance was called. At about 8.13am, paramedics confirmed that he was dead.

4. The man had been using a range of drugs, including heroin, LSD, crack and cannabis, since the age of 16 years and had been a client of Trafford Community Drugs Team (CDT) on and off since 1996. He had committed a series of offences, primarily to support the addition, two of which had resulted in custodial sentences. He had tried to overcome his dependence on drugs and succeeded from time to time but always relapsed. Recently there had been difficulties with his attendance and behaviour at the Substance Misuse Service Centre at Sale.

5. When he was admitted to Manchester, the man told staff that he had a drug problem and, following a urine test, he was recommended for the Detoxification Unit, which is on H Wing, and prescribed an initial dose of 120 mg of Dihydrocodeine (DF118). He was admitted to H Wing the following day and placed on an eight-day detoxification programme. He had taken the prescribed medication up to the time of his death. Dihydrocodeine has been widely used in the Prison Service to mitigate the pain of withdrawal from opiates. It is not an opiate substitute and is not licensed specifically for the purpose of detoxification treatment. In common with other prisons, Manchester is currently developing an alternative detoxification regime with a wider range of treatments.

6. The man told a number of staff that he had never attempted suicide or self-harm and did not feel like harming himself. He was not considered to be at risk and was not the subject of an F2052SH at any time during his period on remand. He spoke to some fellow-prisoners about killing himself. This information was not passed on to staff.

7. Those who knew the man described him as a likeable individual whom it was difficult to get cross with. His keyworker at the hostel where he lived said that he considered himself to be a failure, that he had let his parents down and had no self-worth.

8. During a visit the investigators made to the man's parents, at which his brother and sister were also present, it was made clear that the family felt the system had let them down, that they had been treated indifferently and given inaccurate information when they visited the prison. They also made comments in respect of the treatment and level of care extended to him by the CDT and the prison.

9. With few exceptions, policies and contingencies for the prevention of and the follow up to a death in custody were in place, of a good standard and generally adhered to. However, two roll checks before the man was found reported that all prisoners were accounted for. Given the clinical situation when he was found, it is possible that the officers who carried out the checks may have mistaken a leg that was protruding from behind the privacy screen for someone using the toilet.

10. The police are satisfied that there are no suspicious circumstances.

11. The report makes six recommendations for the care of prisoners. There are additional recommendations about contingency planning, action in the event of a death and to commend two members of staff.

THE INVESTIGATION PROCESS

12. The investigation was opened on 23 June 2004. Notices announcing the investigation were made available to all staff and prisoners. Relevant documents were examined and copied where appropriate. A total of 28 statements were taken or submitted.

13. Manchester prison's performance against relevant Standards and Baselines was examined. A review of Suicide and Self-harm Prevention Measures PSO 2700 and the Follow up Procedures for Death in Custody PSO 2710 was carried out. Contingency arrangements were examined.

14. The investigators visited the man's parents, and his brother and sister, so that they could raise any concerns that they wished to see included in the investigation.

15. The Chair of the Professional Executive Committee of the North Manchester Primary Care Trust conducted a clinical review of the man's care in prison.

16. Additional enquiries were made by correspondence about the detoxification regime at Manchester.

17. A list of staff and prisoners from whom statements were taken, and a synopsis of the manner in which they were involved, is detailed below.

18. A prisoner who was a friend of the man and who was received into the prison with him.

19. The nursing assistant who carried out the Health Screening on the man's reception into the Prison.

20. The prisoner who shared a cell 4.19 in G Wing on the night of 18 June 2004 with the man who died.

21. The officer who interviewed and completed the man's Induction documents on H Wing on 19 June 2004.

22. The staff nurse who interviewed on H Wing on 19 June 2004 to determine the nature of the detoxification to be used.

23. A prisoner who was an H Wing Listener, who spoke with the man over the weekend of 19 and 20 June 2004.

24. A second H Wing Listener who spoke with the man.

25. A prisoner on H Wing, who was told by the man that he was going to kill himself and how he would do it.

26. The Night Duty Officer on H Wing on the 20/21 June 2004.

27. A prisoner who alleged that on the night of 20 June 2004 the man was refused a Listener by a member of staff.

28. The prisoner who shared a cell with the man on the nights of 20 and 21 June 2004 and discovered his body at about 7.15am on 21 June 2004.

29. The officer who, on 21 June 2004, carried out the roll check on H3 at about 6.45am hours.

30. The first officer on the incident scene.

31. The senior officer (SO) in charge of the ECR.

32. The SO who attended the scene, formed the view that the man was dead and held him whilst he was cut down.

33. The staff nurse who was Hotel 1 (emergency response) and who attended the scene and took the view that the man was dead.

34. The officer who cut the ligature that the man was suspended from.

35. The duty governor on 21 June 2004 and who attended the incident scene.

36. The nurse who complained about the radio communications during the incident.

37. The Acting Healthcare Manager, who attended the scene and called the ambulance.

38. The HCO who attended the scene and removed the ligature from the man's neck.

39. The HCPO who attended the scene.

40. The Orderly Officer and attended the incident.

41. The manager of H Wing.

42. The officer who was a member of the Dedicated Search Team (DST) and who assisted in the collection of evidence for the police.

43. A member of the Independent Monitoring Board (IMB) who was called in that capacity to monitor events.

44. The deputy governor who attempted to visit the man's parents.

45. The chaplain who visited the man's family at their home.

46. The officer who after the incident looked after the man's cellmate.

47. The SO who was requested by the police to reseal cell H3.8.

HMP MANCHESTER

48. HM Prison Manchester is located in the city centre. It is a Core Local Prison and is part of the High Security Estate. The prison was completed and opened in 1868. It is one of the few prisons that have been market tested, first in 1993 and again in 2001. On each occasion the Public Sector bid was accepted.

49. The prison has a Certified Normal Accommodation of 961 and an Operational Capacity (Overcrowding Figure) of 1,269. There are nine wings constructed in two radial patterns, one of four wings (the upper prison), the other of five (the main prison) and a supporting infrastructure including a Healthcare Centre, kitchens and extensive workshops. On 20 June 2004, there were 1210 prisoners being held when the prison was locked up for the night. The man who died was located in H Wing, the Drug Detoxification Unit, in Cell H3.8.

50. The last report of combined standards and security audit was in August 2003. This was rated as 'Good' with no main issues arising. The Healthcare provision was described as green on the traffic light system and employment and full time training/education was put at 70%.

51. Before the man's death, the most recent 'non-natural' deaths at HMP Manchester were on 23 December 2002, 2 July 2003, 15 September 2003 and 13 November 2003. Action plans arising from the recommendations have been prepared. Actions have been completed in many cases and target dates have been set for outstanding items.

52. HM Chief Inspector of Prisons has not inspected the prison in the previous 12 months. However, during this investigation an Inspectorate Team arrived in the prison, on 5 July 2004, to commence an unannounced inspection.

THE EVENTS OF 18 TO 21 JUNE 2004

53. The man was received into HMP Manchester during the evening of Friday 18 June 2004. A prisoner travelled in the vehicle from the court with him. In the Reception Building, the usual documents, including the Core Record, Cell Sharing Risk Assessment, Property Sheets and a Private Cash Sheet, were completed and the man was issued with information about the prison.

54. During the reception process, a nursing assistant carried out the Health Screening. The man told her that he had never attempted to harm himself, had no concerns over his physical health and had received treatment for mental illness but could not remember the details. He said he had received medication for depression, but he could not remember the name of the drug or the dose and said he had not seen a doctor in the last few months. He gave the name and address of his GP.

55. The nursing assistant recommended that the man see a doctor, and be admitted to the Detoxification Unit on H Wing. A note requesting that his GP be contacted (the surgery being closed for the weekend) was attached to the Inmate Medical Record (IMR).

56. The man's GP subsequently told the investigation team that he was not prescribing anti-depressants for him at the time of his death. He had a prescription for one month's course of anti-depressant Escitalopram at 10 mg once per day in December 2003. At the same time, the GP had referred him to a specialist for a urological problem. He did not return for a repeat prescription and, when the GP saw him again in March the man said he did not require more anti-depressant tablets as he was feeling better.

57. A urine test in the prison reception proved positive for heroin and amphetamines and the man also admitted to using cannabis. The Detox Regime Treatment Card shows that he was prescribed and given Dihydrocodeine (DF118) 120 mg on 18 June. The nursing assistant said in her statement that there was nothing about the man that caused her any special concern.

58. In the event, the man did not go to H Wing that night but to G Wing. It appears that this happens from time to time but no explanation could be given as to why. He was given a General Induction and the First Night Induction Programme document was completed. It was noted that he said he was not suicidal and had no history of self-harm. He was not sure if he had been offered a phone call in reception but had not made one. The section on telephone calls in the F2051A Wing History Booklet was not completed and I am unable to confirm whether the man was offered a call.

59. The man was allocated to Cell 4.19 on G Wing which he shared with another prisoner. His cellmate spoke to him a number of times and concluded that he needed a 'Detox' and, given the nature of his offence, that it was likely he would be released when he went back to court. The man had attempted to sleep on a chair and his cellmate told him to get into bed. He did so but slept in his

clothes. Nothing was said that suggested that the man was contemplating harming himself.

60. Early on Saturday 19 June, the man was moved to H Wing where he went through further induction. An officer conducted the induction process and explained the Wing routines. The Detox Referral Form, the Drug Dependency Centre Compact and the Manchester Prison Compact were completed and this was recorded in the F2052A Wing History Booklet. Contrary to what he had told the nursing assistant, the man stated that he had not suffered from depression, and confirmed that he had never self-harmed.

61. A staff nurse was interviewing newly admitted prisoners who had declared they had drug problems. She started at about 9.30am and interviewed a number of prisoners including the man who died. He told her that in addition to his current use of heroin, he had used cannabis and LSD from the age of 14 years and crack from the age of 16 years. He was recommended for an 8-day detoxification course of DF118 (Dihydrocodeine) three times a day. The Detox Treatment Card shows that he commenced the course at noon that day and continued up to and including the teatime dose on Sunday 20 June 2004. The staff nurse stated that at no time did the man behave in a way that caused her to think he was going to harm himself.

62. The prisoner who had travelled to the prison from court with the man, met up with him again on H Wing on Saturday morning. He said they had known each other for about 12 years. It appears that the man was not feeling well and kept going to the Wing toilet to be sick. On the Sunday his friend saw him again and the man told him he felt that he wanted to kill himself because he was in pain. His friend did not know how to 'take' him as he was feeling the same himself. He also stated that the man had approached an officer about how he felt but the one he approached would not talk to him as it was locking up time. He could give no more details of the alleged approach.

63. One of the Listeners located on H Wing said he first met the man on Saturday morning and gave him advice on how to obtain clean clothing and how to have his clothes laundered. He saw him again the following day, Sunday, when he gave him a brew (beverages) pack in the morning and spoke to him at teatime when he had indicated he was okay. The Listener said, "There was no indication that he was about to take the action he did and I was shocked when I heard."

64. As a result of the advice given by the Listener on Saturday morning, the man went to the Wing Laundry which is run by another Listener. He told the man to come back the following day, as he was busy. This he did and was given fresh clothing. He returned later with his own clothes for laundering but was somewhat rude to this Listener telling him to, "fucking wash that". He also said that he wanted a word with him but never came back.

65. As a result of the notice requesting information, another H Wing prisoner was interviewed. He stated that both on Saturday and Sunday, whilst in the queue for medication, the man had told him and others that he was going to kill

himself and how. On the first occasion, he then laughed but not on the second. The prisoner formed the view that it was attention seeking and, "didn't tell anyone".

66. On the evening of Sunday 20 June 2004, the man was located in Cell 3.8 on H Wing with a new cellmate. There were 68 prisoners on the Wing when level 1, which has a separate function, is included. The routine for Saturday and Sunday is that all prisoners are locked in their cells at about 6.00pm there being only two staff on duty. The Night Patrol Officer for H and I Wings came on duty at about 7.00pm. He received a briefing and checked all prisoners in the Wings and reported the roll correct to the Night Orderly Officer. He said it was a quiet night with only two or three cell call bells being pressed.

67. A prisoner was located in Cell 4.9 in H Wing, when he heard a cell buzzer (call bell) sound at about 22.30. He then heard an officer say, "You are getting no fucking Listener, you're just after tobacco." He did not hear what was said to the officer and had no line of sight as his cell is on the level above and to the right of cell H3.8. The prisoner said he was "one hundred percent" certain that it was the man who died who had made the request.

68. The man's cellmate said that the man never made a request for a Listener when he was present. He also said that he had accidentally pressed the call bell and subsequently apologised to the officer who said he was an idiot. The cellmate had retorted that he was not an idiot and told the officer to, "get on with his fucking job". The man had subsequently asked him to press the call bell but he felt unable to after the exchange with the officer.

69. The cellmate said that he and the man had watched the film 'Goodfellows', which had finished at about 1.00am on Monday 21 June. They had a "little bit" of a disagreement because the cellmate wanted the television turned down, as he had not slept because of the man's shouting and banging the previous night. They then had a conversation about their children. The man, who had been lying in the top bunk, got out and made his bed up. About half an hour later, the cellmate heard the man call his name quietly. He did not reply and all went quiet. The cellmate woke up periodically during the night to turn the television down, the last time at about 6.00am. He was not aware if the man was in his bed at that time.

70. At about 5.30am the Night Patrol Officer carried out a roll check before going off duty. He stated that he "could clearly recall accounting for all prisoners, some were in bed, some were sleeping on the floor and a couple were already up". He explained that prisoners in the unit often sleep on the floor because they are prone to falling out of bed during Detox.

71. On Monday 21 June, H Wing had a full complement of staff, there had been no changes to the number of prisoners and unlocking would be at 7.30am.

72. An officer, who normally works on K Wing, was working additional hours, had come in early at about 6.30am and had been detailed to take over from another officer. This she did at about 6.35am and carried out a roll check immediately

afterwards. She said that she accounted for the 58 prisoners on H Wing Levels 2, 3 and 4 and signed the roll check document on the Centre to that effect.

73. At about 7.00am another officer arrived for duty on H Wing and took over from her colleague, who had checked the roll, unlocked those who were going to court and was now on her way to Reception.

74. The man's cellmate stated that he got up at about 7.00am and saw his leg sticking out in front of the toilet. He asked him if he was okay and then noticed the string round his neck. The cellmate told the police in his statement to them, that he could recall the man holding what appeared to be the cord from his tracksuit bottoms on the Sunday.

75. At about 7.10am the call bell from Cell 3.8 was rung and the officer, who was on level 3, responded. On her arrival at the cell she looked through the observation window and saw the cellmate who said, "He is dead, Miss." He then indicated that he was hanging. She called for assistance and unlocked the cell. The man was behind the toilet privacy screen at the end of the bunk bed on the left side of the cell. He was in a sitting position, with one leg sticking out and the other was over the toilet. There was a ligature, possibly a lace or the cord of a tracksuit, round his neck and tied to the top of the bunk bed. She noted he was a grey/purple colour and that his head was to the left side.

AFTER THE MAN WAS FOUND

76. Subsequent events are recorded in three logs, the first the Incident Log maintained in the Emergency Control Room (ECR), the second the Incident Scene Log and the third the Greater Manchester Police Major Incident Scene Log. Significant events are detailed below and, not unusually in the initial confusion of such incidents, times and the versions of interactions vary between logs and individuals.

77. The senior officer (SO) in charge of the emergency control room (ECR) stated that there was considerable confusion in the room due to the fact that a new radio system was being introduced. She said that a radio request for medical emergency response (radio call sign Hotel 1) to attend H Wing ASAP was received at about 7.15am. The ECR Log records this at 7.17am. A 'couple' of minutes later a message was received from the wing SO that there was a suspected death in custody on H Wing.

78. The wing SO attended at Cell 3.8 at the request of the first officer at the scene. In his statement, the SO says that he entered the cell which had been unlocked and describes how the man was found. He added that his eyes were open and bulging, his tongue was sticking out and appeared to be swollen and his head was slightly to the left-hand side. He said he checked the man's pulse. He was cold to the touch and the SO formed the view that he was dead. However, he called for medical assistance on his radio and informed the ECR by phone and then returned to the cell. The cellmate, who was visibly shaken, was taken out on to the landing and subsequently located with the second Listener.

79. A staff nurse responded to the radio call for medical assistance and stated that she arrived at the cell at about 7.20am and checked the man. She noted that his tongue was out and swollen, that he was very purple, his pupils were fixed and dilated and there were no vital signs. She took the view that he was dead and did not attempt to resuscitate.

80. The wing SO then went back to the sterile area to obtain the ligature scissors but another officer arrived and collected them. They returned to the cell, the SO supported the man and the officer cut the ligature.

81. The duty governor, was already in the prison and he was called to the ECR and was briefed by the ECR SO before going to the cell at about 7.15am. He was given a further briefing by the wing SO and informed by the Health Care Principal Officer (HCPO) that there was no point in carrying out resuscitation. He did not enter the cell as it was a potential crime scene. He instructed an officer to open a log, one Principal Officer (PO) to supervise the remainder of the top prison, and another PO to supervise activities in the Wing and to inform the other prisoners of the incident and that a Dedicated Search Team should remove the man's clothing and that of his cellmate, as possible evidence. Subsequently, at about noon, he arranged a hot de-brief. Unfortunately, neither Healthcare nor ECR staff were included.

82. A nurse, after some difficulty with his radio, relayed details of the incident to the HCPO, who collected the emergency bag and attend together at H Wing with a Health Care Officer (HCO) and another HCPO arriving at about 7.30am. At this point he was not aware that the staff nurse had already attended. He checked the man for vital signs, there were none and he decided it was pointless carrying out CPR. He then requested the HCO to carry out an independent check and she formed the same view. The first HCPO then instructed that an ambulance be called as there was no medical officer in the prison. The instruction to call an ambulance is timed at 7.45am in the ECR Log.

83. At this point there is some confusion as to whether the ligature had been cut. The first HCPO stated the man was still hanging, but the HCO said that there was a ligature round his neck and that it had previously been tied to the top rail of the bunk bed but had been cut. The HCO then removed the ligature from around the neck, which tends to support her version of events. The second HCPO stated that the man had been cut down and was leaning against the bed, and confirmed that the HCO had attempted to cut the ligature from around the neck and that the knot slipped and came away in her hand.

84. The PO who was the Orderly Officer (the senior uniformed officer on duty) attended the scene with the Duty Governor and sealed the cell. The Scene Log shows that this was 7.40am. He subsequently unlocked and resealed the cell to allow authorised access. He then called for Care Team support from an OSG and later collected and collated the documents and statements required by Prison Service Instruction 20/2004 in the event of a death.

85. The Paramedic Car is shown in the ECR Log as arriving at the gate at 7.52am and the Ambulance at 7.54am. Death was confirmed at 8.13am. The Police arrived at 8.00am.

86. The PO who was the H Wing Manager organised medical treatments and hot water for the other prisoners, carried out a review on the one prisoner on an open F2052SH (suicide risk file) on the wing, supported the staff involved and generally oversaw activities. Subsequently, he gathered the Listeners and Wing Cleaners together and asked that they advise staff if there was anyone they thought was vulnerable following the death.

87. Two officers who were members of the Dedicated Search Team, collected and bagged the clothing from the man and his cellmate. The cellmate was then located in Cell 3.19 on H Wing. At this juncture the staff nurse was checking on his condition. He was subsequently admitted to the Health Care Centre for observation.

88. A member of the Independent Monitoring Board, was informed of the incident and arrived in the prison at about 8.40am and went to H Wing to monitor events. She said that she observed nothing that caused her any concern and prepared a report covering events for several days after the incident.

89. Between 9.00 and 10.00, the deputy governor went with the Roman Catholic went to inform the man's family of his death. Having arrived at the address

recorded for his next of kin, they were told by the occupant that the family had recently moved and that they did not have the new address. Through the Estate Agent who had acted for them during the sale, they were able to make contact with the man's parents, who were in Spain, and informed them of the tragedy. They flew home that evening, and met the chaplain the following day. He accompanied them to the formal identification and led the family in prayers.

90. Another officer had been carrying out a supportive role for staff and prisoners. At about 1.15pm, after some confusion between the police and prison authorities as to who was responsible for arranging the undertaker, the man's remains were removed. The officer states that the police officer in attendance was asked, but did not require the cell to be resealed. The officer and her colleague carried out a Cell Clearance and found four letters from the man to his parents, a keyworker at the hostel, a friend at the hostel and a recent girlfriend. The letters were handed over to the Police.

91. At about 7.34am on 22 June 2004, an SO received a telephone call from the police officer during which he requested further information on the man who had died and also requested that the cell be resealed. The SO informed the police officer that the cell had been cleared and cleaned. He renewed the request to have it sealed.

92. The incident was reported in the required manner, an entry was made in the Governor's Journal and a Notice was issued to both Staff and Prisoners informing them of the death. The Governor wrote a letter of condolences to the man's parents and the Deputy Governor wrote to inform the Coroner of the circumstances.

93. The Staff Care Team attended and were available to all those who were involved albeit that some did not feel they needed support and one or two were not contacted. Not all staff involved were invited to the de-brief meeting.

MATTERS RAISED BY THE MAN'S FAMILY

94. On 2 July 2004, my investigators went to see the man's family. The family raised in particular the following concerns:

95. They suspected that the detoxification regime in the H Wing was crude and standardised, not taking account of the varying needs of individuals. They asked how it compared with what would be provided in an NHS hospital. They said that the man had previously been through detoxification in Prestwich psychiatric hospital.

96. They felt that obvious potential ligatures such as laces and track suit cord should have been removed, particularly as, whilst undergoing detoxification, individuals are likely to behave in an erratic and irrational manner.

97. They asked about the distribution of medication throughout the day since if the last dose was issued in late afternoon it would be wearing off by morning.

98. They were critical of the Community Drugs Team, who they believed had cut the man off for being late and missing appointments. They felt he had been left with no option but to go to prison where he thought he would be safe.

99. They wanted to know if the man would have been given the opportunity to make a phone call in Reception.

100. They felt that when they met the Deputy Governor at the prison he had seemed in a hurry and had not taken the trouble to be in possession of all the facts and that this showed a lack of appropriate respect and concern. They were told there were no letters and this was incorrect.

101. Overall they said that the system had failed the man and taken their son and brother away.

CLINICAL REVIEW

102. The clinical reviewer was given access to the Health Care Standards, the man's IMR, staff statements and the Detoxification Protocol. His report is attached as an Annex to this report. In summary, he makes the following points.

- The quality of initial health screening was adequate.
- The drug detoxification methodology was conducted in accordance with the described protocol.
- The quality of medical documentation was adequate and appropriate.
- No deviation from the healthcare standard was observed.
- CPR was clearly inappropriate.

103. He concludes that the man's death in custody seems to have been an unpredictable event. Health screening was carried out in an appropriate manner, with no omission observed.

KEY ISSUES

104. The man had a history of offending going back nearly 10 years. There is little doubt that the cause of his criminal behaviour was the need to support his drug abuse. He was clearly a likeable individual and came from a loving family, which makes his death even more tragic.

The man's contacts with the community drugs service

105. The man had been a client of Trafford Community Drugs Team (CDT) intermittently since 1996. The CDT has prepared a report of their contacts with him.

106. In December 2003 the man was prescribed Subutex – which suppresses the effect of opiates - but he collected only the first day of medication and did not attend the appointment for a week later with the doctor. Nor did he attend an alternative appointment offered for 8 January 2004.

107. He went to the CDT on 22 January but left before being given a doctor's appointment and declined treatment. He went back on 28 January but was unable to give a urine sample, which was necessary before medication could be prescribed, and was given assessment and doctor's appointments for 9 February which he attended.

108. The doctor prescribed methadone but the man did not collect it, saying, on 13 February, that he did not want two habits. He came back to CDT on 16 February but left before seeing the doctor. He had used the needle exchange, but came back but too late to see the doctor. He was given an appointment for 24 February when he was initiated on to a methadone programme with supervised consumption but did not attend the follow-up doctor's appointment on 1 March. It seems he maintained regular contact with the CDT while taking methadone up to 16 April, when he failed to collect his methadone. CDT were unwilling to provide a fresh prescription until they had a urine test result and, on Monday 19 April, offered a doctor's appointment for Thursday 22 April. The man was abusive to staff and was warned orally, then, on 22 April, by letter, that if he repeated this he would be banned from CDT. He failed to attend for his appointment on 22 April. He was given a further appointment for 10 May.

109. On that day he attended late and was not seen by a doctor. A further appointment was given for 21 May and he was told that if he failed to attend he would have to wait a month for a further appointment. However, the appointment had to be re-arranged by the doctor for 27 May. The man failed to attend and was sent a further appointment for 16 June at 4.20pm. He arrived at 4.40pm and was not able to be seen. He would not in any event have been able to receive medication because he had not given a recent urine sample.

CDT's policy of confidentiality

110. There were two occasions on which CDT declined to answer enquiries about the man who died. His mother contacted CDT on 20 February. The CDT

report says his keyworker was able to give general information but was unable to discuss his case with her because the man had not given consent. When he attended on 23 February, the man expressly refused consent to discuss his case with anyone. On 18 June his hostel keyworker contacted CDT but no information was given because the man had not given his consent.

111. The man's keyworker had a keyworking appointment with the man on 16 June. He told her he was not allowed to go to the Community Drugs team any more because he was not keeping appointments. The keyworker telephoned CDT but they were not open that afternoon. She phoned again on 18 June and a CDT worker called back. The keyworker asked if the man was keeping his appointments. The CDT worker said they could not share that information with her because of their obligation of confidentiality. The keyworker explained that she had a document signed by the man on 4 June 2004 giving permission to liaise with the CDT. The CDT worker offered to speak to the man to seek his permission for CDT to share information but felt unable to disclose any information without that express permission.

112. The keyworker told my investigators that each hostel resident has an individual support plan to suit their particular needs. For the man's plan, the keyworker needed to be able to liaise with drug agencies because he was not going to be able to keep appointments without support. The keyworker said that, with other agencies, she and her colleagues are able to fax the consent document in which the resident agrees that other agencies should share information with the key worker. However, CDT does not consider that authorisation sufficient.

113. CDT's review concluded that they had practised in a safe manner and encouraged the man to access the service. They felt they had been as flexible as they were able, and offered many doctor's appointments and were keen for him to be initiated and retained in treatment. They concluded, however, that if there had been a Tier 2, low threshold service and/or an assertive follow-up available in the area, he might have found it easier to access.

114. CDT's report illustrates the chaotic lives that drug users lead and the challenges faced by those who work with them (just as for families) in drawing a balance between firmness and understanding, whilst also managing the logistics of a providing a service. It also depicts the man's vacillating resolve. It is clear from the report and documents submitted by the CDT that they acted within their policies in their response to his failure to turn up, being late for appointments, confidentiality and abusing their staff.

115. The first point in CDT's statement of 'Rights and Responsibilities' assures clients of a confidential service. I have no doubt this is an essential principle for many clients and that CDT is right to attach importance to it. I wonder, however, whether there is any scope for the service to work in greater collaboration with the other supports to which drug users turn. For example, I wonder whether clients are asked at any stage whether there are particular people or agencies in whom they have confidence and to whom they would authorise limited disclosure in the event of non-compliance with their treatment programme. I realise this presents difficulties but suggest that consideration

might be given to this in order to capitalise on the network of resources that might be available when a client is in crisis.

Admission and induction at Manchester prison

116. On admission to Manchester prison, the man was not presenting in a manner that would have indicated to staff that he was vulnerable to self-harm and he had no known history to indicate that he was at acute risk. He gave contradictory information about a history of depression, but my subsequent enquiries of the GP established that he had not sought treatment for depression save for a short period six months before his death.

117. We learned that the man had indicated, to a number of prisoners, that he intended to self-harm but they did not report the conversations for a variety of reasons. The induction process, including the health screening, was carried out in a proper manner save that there is no record that Andrew was offered a telephone call.

Access to the telephone

118. Newly admitted prisoners are normally offered a phone call in reception. The phone used for this is at a counter with no sense of privacy. Andrew may have been offered and declined a telephone call in reception, even though this is not recorded. The man's sister told us that he was inclined to telephone her when he was in trouble and she was surprised that he had not done so from prison.

119. Prisoners are known to be particularly at risk of suicide in the first few days of imprisonment. Prisoners withdrawing from addictive drugs are especially likely to experience distress. For prisoners fortunate enough to have strong family links, contact can be a protection.

120. It used to be common practice for prisoners to be given a £2 phonecard on arrival in a prison. That meant that during association next day they could use the telephone to call friends or relatives. Most prisons no longer use phonecards but instead each prisoner has a PIN number for what is called a PINphone account. I am told that it takes up to a maximum of two days for a PINphone account to be set up. The man was admitted on a Friday afternoon. It seems unlikely he would have been able to make any telephone calls during the weekend.

Detoxification

121. The man gave the staff no reason to believe that he was at acute risk. But all prisoners withdrawing from addictive drugs in prison are potentially vulnerable.

122. I asked the prison to comment on certain aspects of the detoxification regime. The Primary Care Manager replied on behalf of the prison in a letter of 30 November 2004.

123. The medication prescribed at Manchester at the time for prisoners withdrawing from opiates was Dihydrocodeine (DF118). A prisoner using opiates was given an initial dose on admission, located in the detox wing, interviewed by nurses the following morning and prescribed an eight-day regime of DF118 in progressively reducing doses. The clinical reviewer has confirmed that the man's treatment was consistent with the detoxification regime in use at the time. The system was introduced in about 1996 after collaboration between the then senior medical officer and an independent specialist in the clinical management of addiction who was contracted to the prison by an addiction unit attached to Prestwich Hospital.

124. Dihydrocodeine is intended to provide pain relief mitigating the symptoms of withdrawal. It is not licensed as an opiate substitute to treat dependency. Dihydrocodeine has historically been used widely for detoxification in the Prison Service. The Primary Care Manager commented that, although not considered ideal, it was considered the safest option in the environment that detoxification was taking place.

125. I am told that plans are well advanced to extend the prescribing options at Manchester. It is intended that clinicians will have the option to prescribe methadone, buprenorphine or Lofexidine which are all licensed for the treatment of dependency. The initiative is part of a closer working partnership between the prison and community services.

126. The man's parents questioned the capacity of a standard regime to treat patients with individual needs. The Primary Care Manager said that it was not ideal but that patients were observed regularly and if they were seen to be experiencing unusual or relatively severe symptoms dosage could be adjusted appropriately. However, she commented:

127. "It is our experience that many drug users use extremely chaotically and in very large amounts, and it would be unsafe to substitute sufficient prescription drugs to completely eradicate withdrawal symptoms. In some cases some degree of discomfort is inevitable, whether physical or psychological at some time. Our intended partnership with community prescribers will align our regime more closely to community practices. That said, however, prescribers themselves are cautious and are anxious that protocols and practices take into account the uniqueness of the prison environment and the risks inherent therein."

Issuing of medication

128. On weekdays, medications are issued from 7.30 to 8.30am, 11.00 to 12.00 noon and from 6.15pm. At the weekend the times are 8.15 to 9.00 am, 11.15 to 12.00 noon and 4.15 to 5.00pm. Prisoners are required to ingest medication in sight of staff when it is issued. The prison was asked to comment on the longer overnight interval between treatments at the weekend.

The Primary Care Manager comments in her letter

129. "Because of the short half life of Dihydrocodeine, a re-occurrence of withdrawal symptoms can occur between the evening and morning doses at the weekend. This is not considered overly problematic, and it can be argued that it contributes to breaking the 'repeat tablet taking' cycle referred to in Department of Health guidelines, which reinforces drug-taking behaviour."

130. I do not think it satisfactory that detoxification at the weekend should provide relief inferior to that provided on weekdays, especially when prisoners are locked up for long hours overnight.

Safeguards against suicide and self-harm

131. The man's parents have strongly argued that prisoners experiencing the pains of detox should not be left with easy ligatures. They understood that a person withdrawing from heroin would not be left with a cord or laces in a police cell or in hospital.

132. This is a difficult issue. There are many means by which a determined person can end their lives. Shoelaces and tracksuit cords are not the only possible ligatures. Depriving prisoners of the ordinary stuff of normal life can itself generate distress. The fact that belts, laces, cords and other potential ligatures are not removed from prisoners is in endeavour to achieve as near to a normal environment as possible. But withdrawal from hard drugs is not a normal experience and extraordinary vulnerability may call for extraordinary measures. In view of the possibility of irrational and erratic behaviour by some prisoners undergoing detoxification, I believe that consideration should be given on an individualised basis to removing obvious ligatures, such as lace and tracksuit cords, during this period.

133. The prison has extensive written guidance for staff on suicide and self-harm (SASH) prevention but there was no record of some of the staff involved in the incident having undergone training in SASH prevention.

Overnight observations

134. The wing officers stated that they had accounted for all prisoners during roll checks. The man's condition when discovered indicates that he may well have been already dead by the time of the two roll checks in which two officers apparently accounted for all prisoners. Neither remembered the particular cell. It is possible that they may have mistaken the leg protruding from behind the screen as someone using the toilet. I also note that we were told that prisoners on detox sometimes sleep on the floor.

135. Officers checking prisoners on the detox unit during periods of lock-up should do so with a view not simply to counting the numbers but also with the aim of identifying any prisoners in distress.

After the man was discovered

136. The clinical reviewer is satisfied that the clinical response was appropriate when the man was discovered. Given the condition described and the judgments of healthcare staff, the reviewer concluded that CPR was not appropriate.

137. However, there was delay in cutting the ligature and calling an ambulance.

138. The cell was sealed initially before an authorised clinician had certified that the man was dead. It seems clear that he was beyond help but I do not think it respectful or safe for a cell to be sealed before death is authoritatively declared.

139. There was confusion between the prison and the police about arrangements for removing the body and about release of the cell.

Contact with the man's family

140. The efforts made by the deputy governor and chaplain to make contact with the family are commendable. There was confusion between the police and prison authorities over who was responsible for arranging the undertaker and this must be resolved for the future.

141. The man's family felt that the deputy governor was not well informed when he met them. The deputy governor told the investigation team at the start of the investigation that he deeply regretted that, when he saw the man's family initially, he was not aware that letters had been found in the cell.

RECOMMENDATIONS

For the care of prisoners

1. The Governor should ensure that newly admitted prisoners are offered a telephone call and that this is recorded in every case. Consideration should be given to ways of ensuring that prisoners are able to make phone calls from the wing without delay

2. The Governor should ensure that the detoxification unit provides the same quality of care at the weekend as during the week.

   Response from HMP Manchester:
   As referred to in the report HMP Manchester has reviewed it's detoxification provision and will establish a service providing consistency of delivery.

3. Given the possibility of irrational and erratic behaviour by some prisoners undergoing detoxification, appropriate risk assessments should be carried out, on an individualised basis, for the removal of obvious ligatures, such as laces and tracksuit cords, during a period of high risk for the purposes of immediate safety and for the shortest possible time.

4. All staff working on the detoxification unit should receive training in the physical and psychological effects of withdrawal, the need to be alert to symptoms of distress and appropriate responses.

   Response from HMP Manchester:
   As part of HMP Manchester's development of detoxification services all staff working within both the detoxification units have received role specific training in conjunction with Manchester Drug Services.

5. Given that the records appear to be incomplete, an audit should be carried out to establish who has been trained in Suicide and Self-Harm Reduction and action taken to ensure that all necessary staff have received training.

   Response from HMP Manchester:
   Following the recent implementation of ACCT, all staff having contact with prisoners with the exception of a small minority have received specific suicide and self-harm reduction training. There is a programme of on-going training which will encapsulate the small number of staff who are yet to receive the training due to sick absence or annual leave.

6. The documents F2052SH Guidance Notes for Staff and What to Look for when Checking F2052SH Forms are examples of good practice and should be shared.

   Response from Safer Custody Group and HMP Manchester:
   As the F2052SH is being replaced by ACCT, it may not be appropriate to share these guidance documents which are used locally.

For contingency planning

7. The Governor should reinforce the action to be taken in the event of a hanging as detailed on page 2 of the locally produced document, 'Suicide Prevention and Self-Harm reduction – Guidance for Staff by Day and Night which is derived from PSO 2700, the Prison Service guidance on preventing Suicide and Self-harm

8. Arrangements should be such that an ambulance is called immediately a prisoner is reported to have been found hanging.

   Response from HMP Manchester:
   We have recently agreed formal protocols with the ambulance service relating to all requirements for entry to and egress from the establishment.

9. The Governor should establish a protocol with the police with regard to respective responsibilities in the event of a death in custody.

10. The handing over of a cell by the prison to the police and its return, in these circumstances, should be formalised and agreed at an appropriate level.

Action in the event of a death

11. All staff involved in such incidents should be invited to the hot de-brief.

    Response from HMP Manchester:
    This is current policy at HMP Manchester, although we acknowledge the comments made in relation to some staff having not been invited to the hot debrief. Additionally a new staff information system has been introduced, which ensures that all staff entering the establishment have access to important information such as hot debriefs.

12. All staff who are involved in such incidents should be contacted by the Care Team.

    Response from HMP Manchester:
    This is the current policy at HMP Manchester, although we acknowledge the comments made in relation to some staff not being contacted.

13. The Governor should satisfy himself as to the appropriateness of the arrangements and procedures for meeting the family of the deceased, having particular regard to sensitivity and the accuracy of the information being given, and take whatever action is indicated.

    Response from HMP Manchester:
    The comments relating to the perception of the family's meeting with the Deputy Governor are extremely regrettable and as a consequence a full review of the arrangements for such meetings are being reviewed in line with this recommendation.

Staff commendation

14. The deputy governor and chaplain should be commended for their actions in tracing and contacting the man's parents.