Investigation into the circumstances surrounding the death of a man at HMP Full Sutton in July 2010

Report by the Prisons and Probation Ombudsman for England and Wales

April 2011

This is the report of the investigation into the circumstances surrounding the death of a man in July 2010 at HMP Full Sutton. He was found at about 6.40am, during a routine check. He had a ligature made from a shoelace around his neck which was attached to the window bars. He was 41 years old when he died. I offer my sincere condolences to his family and all those touched by his death. I am sorry that my report has been delayed.

The investigation was carried out by a senior investigator. I would like to thank the Governor and his staff for their co-operation with the investigation. I am particularly grateful to the prison liaison officer who provided valuable assistance to the investigator. I am also grateful to those prisoners who participated in the investigation.

The local PCT commissioned a clinical reviewer to undertake a review of the clinical care the man received at Full Sutton. I am grateful for his timely review.

The man had been convicted of serious sexual offences against children, and received a long sentence. At various times during his sentence he clearly struggled to cope with his remorse and the impact his offences had on his victims. Part of his progression towards release required him to undertake programmes which focused on his offending behaviour and he found this hard. I have found that he received extensive support from various prison and healthcare staff.

Under national guidelines, the nature of his offences meant that the man was prevented from having contact with any children, including his own, unless detailed risk assessments had been completed. However, he told staff and prisoners that contact with his youngest son was very important to him. Although the necessary procedures had not been followed, he had begun talking regularly to his son. On 29 June, he was told that he would be prevented from doing so. Although he was upset by the news and initially confused, he appeared to accept what he was told. Staff saw no signs that he was vulnerable or a risk to himself. Some prisoners thought he was acting unusually but did not raise the alarm with staff. As a result he was not being monitored under suicide prevention measures when he died.

I make three recommendations as a result of this investigation. One concerns staff recording important information about prisoners in relevant files. The other two relate to the emergency response once he was found. I am pleased to reflect in this final version of the report that the National Offender Management Service (NOMS) has accepted all of the recommendations.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Jane Webb
Acting Prisons and Probation Ombudsman **April 2011**

CONTENTS

SUMMARY

1. The man was charged with sexual offences against children in August 2006. He was remanded into the custody of HMP Forest Bank (a private prison run by the company Kalyx). It was not his first time in prison. Because of the nature of his offences, he was subject to public protection measures meaning that he was not permitted to contact any children, including his own, unless detailed assessments were completed. However, in October 2006, the prison's security governor gave written permission for him to have contact with his youngest son, although the necessary public protection procedures had not been completed.

2. In June 2007, he was convicted of the offences and sentenced to an indefinite sentence for public protection (which is explained on page nine) with a tariff of seven years. He told staff at Forest Bank that he had not been expecting such a long sentence and had considered killing himself, before deciding against it. His mental health was assessed and no concerns were raised.

3. Shortly after his conviction, the man was told once again that he could not have contact with any children unless the public protection measures had been completed. He was told that all of his mail and telephone calls would be monitored. In May 2008, he admitted that he was speaking to his son each week. Staff confirmed that the correct procedures had not been followed and were necessary before contact resumed. It seems that the man did not make a formal application for contact with his son at this stage.

4. At various points during his sentence, the man complained of feeling depressed and was prescribed antidepressant medication. In February 2009, he told staff that he had taken an overdose of his medication because of issues relating to contact with his son. Staff opened an Assessment, Care in Custody and Teamwork plan (the ACCT system is explained on page nine). The ACCT support was ended about two weeks later when he said that he felt more settled and would pursue contact with his son through "formal means". He denied any further thoughts of suicide or self harm.

5. In July 2009, the man transferred to HMP Full Sutton in order to complete offending behaviour programmes. He appeared to settle well and made friends on the wing where he lived. He told both staff and prisoners who knew him that contact with his son was extremely important to him.

6. He continued to deny any thoughts of self harm or suicide. However, he admitted to a history of alcohol and drug use which he thought was linked with his offending behaviour. As a result he was considered suitable for an in-depth programme focusing on substance misuse problems. Staff knew that he found the programme challenging and sometimes upsetting, but he said that he was learning a lot from his participation. He said that he found the support offered by his key worker very helpful.

7. In February 2010, the man became upset during an assessment interview. He said that he found it difficult to talk about his offences and was ashamed of what he had done. He described feeling nauseous, anxious and not sleeping well.

The officer conducting the assessment referred him to the mental health team who assessed him the following day.

8. He met the same mental health nurse regularly for several months. During their sessions, he admitted feeling depressed but denied any thoughts of self harm, saying he had hurt his family enough already. The nurse decided that he should be prescribed antidepressants, the dosage of which was raised in April. Over time, however, he said that he was beginning to feel better and had been given coping strategies.

9. In June, security staff responsible for monitoring the man's telephone calls noticed that he was speaking to his son. He was warned that he must not contact his son unless he made a formal application to do so and the proper assessments had been completed. However, it appears that they continued to talk and so on 29 June, the public protection officer at Full Sutton arranged to speak to him. The officer told him that he would be prevented from calling his son until the procedures had been completed. He was clearly upset by the news and talked to a number of prisoners about it. He said that he had been treated unfairly by the prison.

10. An officer working on the man's wing noticed that he seemed troubled and spoke to the public protection officer on his behalf, seeking clarification. That officer told the man that he was to be allowed to make a final call to his son at the weekend to explain the situation. The officer said that he was very happy when told this. He spoke to his son's mother and his sister on 30 June and appeared to understand the process involved. He gave staff no signs of being a risk to himself. His friends on the wing described his behaviour as unusual, but none raised the alarm with staff.

11. During a routine check at about 6.40am on a morning in July, staff found the man with a ligature around his neck, tied to the window bars of his cell. They went into the cell and healthcare staff arrived, however, he had been dead for some time.

12. I make three recommendations as a result of this investigation. One concerns staff recording important information about prisoners in relevant files. The other two recommendations relate to the response by staff when the man was found. However, I conclude that his actions could not have been reasonably foreseen by staff and, on that basis, his death could not have been prevented.

THE INVESTIGATION PROCESS

13. The Ombudsman's office was notified of the death of the man on 1 July 2010. The investigation was allocated to a senior investigator. She visited Full Sutton on 7 July to open the investigation. During her visit she met representatives of the Prison Officers Association, the family liaison officer and other staff who knew the man. She was also shown around the prison.

14. The investigator was provided with documentation covering the man's time in prison, including his medical records, prison file and the staff incident reports written after his death.

15. Notices were issued inviting staff and prisoners to contact the investigator with any information they felt might be relevant to the investigation. A number of prisoners responded to the notices and were interviewed in August 2010. Members of staff identified as relevant to the investigation were also interviewed. Following interviews, verbal and written feedback was given to the Governor and Deputy Governor.

16. The local PCT appointed a clinical reviewer to undertake a review of the clinical care the man received at Full Sutton. The reviewer and investigator carried out some joint interviews. In addition, the clinical reviewer had access to copies of relevant documentation including the man's medical record and he interviewed additional healthcare staff.

17. HM Coroner for East Riding and Kingston-upon-Hull was informed of the nature and scope of the investigation. A copy of this report will be sent to him to assist with his enquiries.

18. One of the Ombudsman's family liaison officers contacted the man's nominated next of kin, his sister, to explain the investigation process and invite her to raise any concerns or questions. She said that she had spoken to him the day before his death when he had seemed fine. She also thought that he was making plans for the future so his death had come "out of the blue". She mentioned that he was very close to his son, with whom he had just resumed contact after a break of three months. Although she raised no specific questions about her brother's death, she wondered if more could have been done to support him and prevent his death. The man's sister said that she was disappointed that she had not been told of her brother's death until several hours had passed. She also mentioned that the staff who broke the news to her were not from Full Sutton and had limited information about the circumstances. I consider the contact between Full Sutton and the family later in the report. I hope that my report helps to answer any questions the family may have and builds a picture of his time in prison, particularly in the days leading to his death.

19. Since the Ombudsman began investigating all deaths in prisons in 2004, nine prisoners (including the man) have died at Full Sutton, although only one other death was self inflicted. I have found no similarities between the circumstances of the previous deaths and that of the man, or in the recommendations made.

HMP FULL SUTTON

20. HMP Full Sutton, near York, is a purpose built, maximum security prison holding up to 608 category A and B adult male prisoners. The prison holds some of the country's most dangerous prisoners and those who are considered to pose a high risk of escape. All prisoners at Full Sutton must have been sentenced to more than four years and have over 12 months of their sentence left to serve. All of the cells at Full Sutton are single.

21. The prison has three wings dedicated to housing 324 vulnerable prisoners. Prisoners are most often deemed vulnerable due to the nature of their offences but may also include those who are less able to cope on the main prison wings for other reasons. Vulnerable prisoners are generally kept separate from other prisoners.

22. The National Offender Management Service (NOMS) publishes quarterly performance ratings for all prisons in England and Wales. The ratings are based on a set framework and prisons can be rated from one to four (with four indicating 'exceptional' performance). Full Sutton has achieved a rating of three ('good' performance) for the last four published quarters.

HM Chief Inspector of Prisons (HMCIP)

23. HMCIP last carried out an inspection of Full Sutton in November 2010 but the inspection report has not yet been published. The most recent published report relates to the announced inspection carried out in November 2007. The inspection report noted the "considerable progress" made at the prison since the last inspection. The prison was praised for remaining a "commendably stable and largely safe" establishment.

24. The Inspectorate found some evidence of good relationships between staff and prisoners. However, they reported that staff on some wings, including B wing (where the man lived), spent insufficient time mixing with prisoners during periods of unlock. Prisoners' perceptions of relationships with staff were "very poor". During this investigation, prisoners interviewed spoke positively of most staff on the wing and said that they were approachable and helpful.

25. A "sound" suicide prevention policy was in place and staff were trained and familiar with the suicide and self harm monitoring procedures (explained further below). The quality of relevant documentation was generally found to be good. However, the Inspectorate was concerned that prisoners' access to Listeners (explained on page nine) and the Samaritans was limited, particularly at night.

Independent Monitoring Board (IMB)

26. Every prison in England and Wales is monitored by an independent board of volunteers drawn from the local community. Members of the Board have access to every part of the prison and all prisoners held there. Part of their function is to ensure the humane and just treatment of prisoners. The Board must report

annually to the Secretary of State for Justice. The most recent annual report available for Full Sutton covers the year ending November 2009.

27. The Board noted the improvements to the delivery of healthcare at Full Sutton since the last annual report. They also praised many of the activities on offer to prisoners. The Board concluded that 2009 had been a year of "consolidation and some commendable progress" across various areas of the prison.

Assessment, Care in Custody and Teamwork (ACCT)

28. ACCT is the Prison Service process for supporting and monitoring those prisoners thought to be at risk of harming themselves. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm himself. The purpose of ACCT is to determine the level of risk, the steps that might be taken to reduce it and the extent to which staff need to monitor and supervise the prisoner. Levels of observations (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and can be set according to the perceived risk of harm. If staff perceive the risk of harm to be very high, the prisoner may be constantly observed, with a member of staff positioned outside their cell at all times. Where the perceived risk is lower, the level of observations may be several times an hour or day. Observations also take place during the night. As part of the process a CAREMAP (plan of care, support and intervention) is put in place and there should be regular multi-disciplinary review meetings. Wherever possible, the prisoner at risk is also included in review meetings.

Listeners

29. Listeners are prisoners who are trained and supported by the Samaritans to provide emotional support to other prisoners. The service is confidential, meaning that Listeners can only pass information to staff (or indeed Ombudsman's investigators) in certain limited and very specific situations. Listeners are bound by the confidentiality agreement even after the death of a prisoner they have supported.

Indefinite Sentence for Public Protection (IPP)

30. IPP sentences apply to those who commit certain serious violent or sexual offences and are deemed to pose a "significant risk of serious harm in the future". The sentencing court sets a minimum period of imprisonment required (known as the tariff), but the individual will only be released after that point if the risk to the public has been reduced. Prisoners serving IPP sentences are generally treated in the same way as life sentenced prisoners.

Public protection procedures

31. The Prison Service Public Protection Manual sets out the procedures prisons must follow when a prisoner wishes to have contact with a child. The procedures apply particularly when the prisoner has been convicted of offences against

children or offences which pose a risk to children. The wishes of the child are paramount. The manual directs that the first part of the process is to ensure that the procedures have been explained to the prisoner. The prisoner must then complete an application form for contact with a specific child or children. The prison must keep a record of all applications and ensure that if the prisoner transfers to another prison the application transfers with them.

32. Once a prisoner has made an application, the child's parent or guardian must be asked whether or not they support the contact. The child's wishes and feelings will be established by the local social services, who should make a home visit.

33. The process is a multi-agency one, and so all relevant agencies must be contacted. This will normally include the police, social services or local children's services department and the probation service. Once information has been gathered from these agencies, a prison senior manager must decide whether contact should be allowed and in what format and frequency. Contact may take the form of telephone calls, letters or visits, or a combination of the three.

Counselling, Assessment, Referral, Advice and Throughcare service (CARATs)

34. CARATs teams operate in every prison in England and Wales. They provide low intensity, non-clinical interventions to prisoners with substance misuse problems. They work primarily with those who use drugs, but can also work with prisoners who use both drugs and alcohol. (The service is not available to prisoners who only misuse alcohol.)

35. Prisoners may refer themselves to the service or be referred by staff. A CARATs worker will assess the prisoner's history of substance misuse and establish their support needs. Interventions on offer might include one to one counselling sessions, group work or specially designed programmes.

FOCUS programme

36. The FOCUS programme is a high intensity Cognitive Behavioural Treatment, delivered to prisoners in the high security estate. Cognitive Behavioural Treatment or Therapy (CBT) is a form of therapy which helps an individual manage their behaviour by changing how they think and act. The programme is designed for prisoners considered to be at high risk of re-offending and with moderate to severe alcohol and drug problems. It is delivered in 59 two hour sessions, including group and one to one work, over five months. At Full Sutton, prisoners attend four sessions a week during the group work element (which lasts for three months).

37. FOCUS uses a multi-disciplinary approach, involving psychologists, CARATs workers, probation, prison and medical staff as appropriate. Suitable prisoners are referred through CARATs. At the end of the programme, the prisoner is given a progress report.

KEY EVENTS

38. In August 2006, the man was remanded into the custody of HMP Forest Bank having been charged with a number of serious sexual offences against children, including members of his family.

39. Due to the nature of his offences, he was told that he was not allowed contact with children. However, in October 2006, the prison's security governor wrote to the man's solicitor. The governor noted that the man's youngest child, a son, was not a victim of the alleged offences or a witness in the ongoing criminal case. For that reason, the governor wrote that he could have telephone contact with his son. It appears that the Public Protection Measures described earlier were not commenced at this point.

40. The man was convicted of the offences on 16 April 2007. Two months later he was sentenced to an IPP sentence, with a tariff of seven years. On 16 June, the day after he received his sentence, staff at Forest Bank carried out a Post Conviction Immediate Needs Assessment. He said that he had not been expecting a life sentence and had thought of suicide but "decided against it". He said that he had "no intention" of taking his life. On 18 June, he was assessed by the prison mental health team, who recorded that there were no concerns about his mental health.

41. Shortly after he was sentenced, staff at Forest Bank began the procedures necessary to establish whether he could have contact with children. Staff recorded that, at that time, he was subject to the highest level of restrictions, meaning that he was not allowed any contact with any children unless the public protection measures had been completed. In addition, all of his telephone calls and post (both incoming and outgoing) could be monitored. No mention was made of the security governor's agreement to contact between the man and his son. According to the paperwork provided to the investigator, the man did not make a formal application for contact with his son at this stage.

42. In January 2008, he unsuccessfully appealed against his sentence.

43. On 14 March, he was assessed by a member of staff from the mental health team following a referral from a member of the chaplaincy team. She recorded her assessment in the medical record. She noted that he was having counselling through the chaplaincy team and had recently told his counsellor that he was thinking of harming himself. He told her that he was missing his children and found extended periods of time in his cell at the weekends, and particularly on Sundays, difficult. She suggested coping strategies and encouraged him to talk to staff if he was thinking of harming himself.

44. The man was examined by a doctor on 9 May, complaining of depression. He said that his mood was "variable", but recently had been "more down than up". He was not sleeping well and felt tired all of the time. He admitted to some thoughts about harming himself but said that he did not think he would act on them. He told the doctor that he had tried to hang himself about six months previously whilst he was in prison, but "did not go through with it". (There is no

other mention of this attempt in the documentation relating to his time at Forest Bank.) The doctor noted that the man had been assessed by a mental health worker, who had decided that no follow up was necessary. The doctor concluded that he probably had "mild depression" and prescribed one month's supply of citalopram (an antidepressant). He also asked to be prescribed sleeping tablets, which the doctor refused, instead giving him advice to help him sleep better.

45. On 23 May, the man attended his sentence planning meeting. (All convicted prisoners should have a sentence plan in place. The plan sets out the targets they need to reach, such as completing specific courses, to proceed through their sentence and towards eventual release.) During the meeting, he said that he had been speaking to his son on the telephone every week. Staff noted that the former security governor had agreed this, apparently without the correct procedures being completed. The procedures were initiated and he was told that his son's mother would be approached for her consent to the contact. He was also told that the social services department would be involved in the decision.

46. During the meeting, staff noted that he appeared to be ashamed and remorseful about his offences. He had reached enhanced status under the Incentives and Earned Privileges (IEP) scheme. (There are three IEP levels: basic, standard and enhanced. The IEP scheme allows prisoners to earn additional privileges, such as extra visits or having a television in their cell, by behaving responsibly and complying with the prison's rules.) Staff thought that he had settled well at Forest Bank. Through his counselling sessions with the chaplaincy team, he had "made some progress in terms of accepting responsibility for his behaviour". He said that he did not want to be released until he "felt confident that he could control his sexual behaviour". As part of his sentence plan, he needed to complete the Sex Offenders Treatment Programme (SOTP). He said that, while he was keen to engage in offending related work, he was anxious about having to discuss his offences in a group setting.

47. The man had another appointment with the doctor on 30 June. He complained of lower back pain, due to a previous accident, and was referred for physiotherapy. Although his history of depression was noted, it appears the doctor did not discuss this any further during the appointment.

48. In August, he told probation staff that he had not yet heard whether he was allowed to resume contact with his son. The prison records contain no other reference to this matter until 10 February 2009, when he was placed on an ACCT plan. The ACCT was begun at 8.30am, after he told a member of staff that he had taken a quantity of paracetamol and ibuprofen tablets at 8.00pm the previous day. (He had been prescribed the medication in December 2008, when he complained of frequent headaches. He had been allowed to hold the tablets "in possession" which means that, following a risk assessment, he was allowed to keep the medication in his cell and take it when he wished.) He told the staff that his ex-partner had refused to allow him any contact with his son.

49. Prison Custody Officer (PCO) A carried out the ACCT assessment interview at 10.45am. During the interview, the man said that he had wanted to "go to sleep

and not wake up", but now realised he had done a "foolish thing". He told the officer that he had never harmed himself before, although he admitted to having thought about suicide in the past. However, he said these ideas had been caused by using drugs and alcohol at the time. The PCO noted that he seemed to be feeling more positive but that his son was "the main focus of his life". The officer advised him to seek advice about how he might re-establish contact with his son.

50. Following the first ACCT Case Review at 1.45pm that day, staff were directed to have a conversation with the man at least once each morning and afternoon and to check him once an hour at night. During the review, he said that he had talked to other prisoners on his wing and felt more settled.

51. Because of his admission that he had taken an overdose of his in possession medication, he was examined by the doctor. A blood sample was taken, which indicated that he had not consumed a dangerous quantity of paracetamol. His medical records were amended to show that he must not be given his medication "in possession" in future. It seems that he was not referred to the mental health team, despite having harmed himself.

52. The second ACCT Case Review took place a week later on 17 February. The man told the staff at the meeting that he planned to contact his solicitor to help resolve the problem of contact with his son. Staff noted that he had no more thoughts of harming himself and decided to close the ACCT. The decision to close the ACCT was reviewed on 24 February. Senior Prison Custody Officer (SPCO) A carried out the review, noting that he appeared to be jovial and confident and there were no concerns about him.

53. The man was transferred to Full Sutton on 20 July 2009 so that he could complete the offending behaviour programmes stipulated in his sentence plan. On his arrival his mental and physical well being was assessed by a member of the healthcare team. She recorded that he had high cholesterol and had recently seen the doctor about this. No record was made of his history of depression, the previous prescription for anti-depressants or his alleged overdose earlier in the year.

54. Other staff who met the man during his early days at the prison had no concerns about him or the risk he might pose to himself. On 18 August, he had an appointment with a CARATs worker, having completed an application form on 29 July. The CARATs worker assessed his substance misuse problems, noting that he had used cannabis, alcohol, amphetamines and ecstasy prior to coming to prison. He said he had not used any drugs or alcohol since he was imprisoned. He told the CARATs worker that he had suffered with depression in 1995 when a relationship ended. It seems that he made no mention of the more recent episode. He said that he had never tried to harm himself and was not currently thinking about doing so. The CARATs worker referred him to the FOCUS facilitators to assess whether he was suitable for the programme. (The CARATs worker continued to meet him, generally on a fortnightly basis, until he began the FOCUS programme in November.)

55. As noted earlier, while at Forest Bank, the man was subject to the highest level of monitoring, meaning that all of his telephone conversations and post were monitored. Security staff at Full Sutton explained that, as a maximum security establishment, every item of incoming and outgoing mail for every prisoner is read by security staff. In addition, his telephone conversations were subject to monitoring, meaning that each call was listened to within 24 hours.

56. On 30 September, the staff responsible for monitoring prisoners' telephone calls raised a concern about him. Senior Officer (SO) A spoke to him and made an entry in his prison file. The officer noted that during a telephone conversation with his sister, he had spoken of "feeling down". He told the officer that he was "fine" and was "just sounding off". He said that staff did not need to worry about him. The SO reminded him to approach staff if he needed to talk to someone.

57. The man's personal officer, made an entry in the prison files in early October. (Personal officer schemes operate in most prisons in England and Wales. Officers are allocated a number of prisoners for whom they act as the first port of call if the prisoner has any questions or concerns.) The officer noted that he had been at Full Sutton for six weeks and had "settled in very well". He had applied for work in the Prisoner Information and Computer Technology Academy (PICTA) workshop and in education (prisoners are paid a small amount for attending education). He had also applied for the Enhanced Thinking Skills programme (an offending behaviour programme) and the SOTP. The officer noted that he was in contact with some members of his family.

58. On 24 October, the man successfully applied to become a Listener. Five days later, on 29 October, he began the FOCUS programme. His keyworker was a trainee forensic psychologist. She was interviewed as part of the investigation, and she said that he was "very open" the first time that she met him. She described him as "honest when he was upset or struggling with something".

59. The keyworker explained that he was concerned about having to talk about his offences in a group setting, but was generally "open to the process". She was asked whether she had ever been concerned about his vulnerability or risk to himself. She said that, although he had struggled with some elements of the programme, he had been quick to ask for help either from the facilitators or other prisoners in the group. She explained that "… you would know if he was having a bad day and he would be very open about that, it wasn't hidden". She said that he never mentioned feeling suicidal or wanting to harm himself.

60. In early November, the man again complained of trouble sleeping saying that it was because of the volume of the television in the next door cell late at night. His personal officer took steps to try to help. By Christmas time, he had moved to another spur on B wing and so the problem was resolved. The officer recorded that he had settled well on his new landing.

61. On 10 February 2010, the man met his offender supervisor to review his OASys document. (Offender supervisors are responsible for the day to day implementation of the prisoner's sentence plan. They write parole reports, attend parole hearings and complete risk assessments. OASys – the Offender

Assessment System – is the standardised assessment tool, developed jointly by the Probation and Prison Services.) During their conversation, he became tearful when talking about his offences. He told her that he felt ashamed about what he had done. He described feeling anxious, being sick in the morning and struggling to sleep. He said that he had asked for an appointment with the mental health team. He told the officer that he was not thinking of harming himself.

62. The offender supervisor was also interviewed during the investigation. She said that the man seemed to be struggling to come to terms with his offences. She described him as honest and always tried to answer her questions fully. During their OASys meeting he talked about having been on an ACCT in 2009. He explained that he had a headache and had wanted to go to sleep, but was "adamant" that he had not been trying to harm or kill himself. He also told her that he had considered killing himself on the day he pleaded guilty to his offences. He said that he had made some preparations to hang himself, but a photograph of his son had fallen from his pocket which he took as a sign that he should not kill himself.

63. The man assured his offender supervisor that he would not harm himself because he had already put his family and his children through enough and did not want to hurt them anymore. She explained to the investigator that, as he talked about his plans for the future, she did not think that he was a risk to himself. He said that he was not currently in touch with his son and planned to contact his solicitor to help him arrange this. He mentioned that he was participating in the FOCUS programme and found it helpful to talk to his keyworker.

64. Following their meeting, the offender supervisor spoke to staff on the man's wing to let them know that he had been upset. Having discussed with him whether he would like to be put in contact with the mental health team, she also spoke to a mental health nurse. The nurse assessed him the following day and noted his conclusions in the medical record. He wrote that he was on the FOCUS programme and struggling to cope with some of the emotions that his participation had raised. The man told him that he felt depressed and that, in the past, he had considered suicide. However, again he stressed that he would not try to harm himself because it would hurt his family too much. The nurse decided that he would make a full assessment of his mental health and then work with him using Cognitive Behavioural Therapy (as explained earlier).

65. On 13 February, the personal officer noted that the man was finding the FOCUS programme difficult. He was also concerned about whether he could telephone his nephew. He asked the officer if the necessary paperwork could be sent to his sister so that she could be asked for her consent to the calls.

66. A week after their first meeting, the mental health nurse assessed the man's mental health. He concluded that he was not suicidal, but was suffering with anxiety and low mood. The nurse recorded that he had given him some CBT worksheets to complete in his own time. In interview with the investigator, the nurse said that the man appeared to be "genuinely remorseful" and "tormented"

by his offences and what they had done to his family. Although at first he found it hard to speak openly about his feelings, in time, he was able to share more with the nurse.

67. The nurse was asked whether the man had ever spoken of harming himself. The nurse explained that the man said that, sometimes, he thought the "only way of dealing with this" was to "end it all". However, the nurse said that he "quickly qualified that" by saying that he would not do anything more to hurt his family. The nurse asked him if he had planned how he would end his life, but explained that he always gave the impression that "he was much more interested in finding a positive solution to his problems". The nurse was clear that, had he had any concerns that the man might act on his ideas about harming himself, he would not have hesitated to place him on an ACCT plan. He was very familiar with the ACCT system and had frequently begun the process with other prisoners when necessary.

68. On 22 February, the man met the offender supervisor again. She recorded that he was "coping much better" and was finding his sessions with the mental health nurse very helpful. She noted that he had begun the training to become a Listener. In interview, the offender supervisor said that she had questioned him about whether it was the right time for him to become a Listener. She explained that she was concerned that the role might be challenging whilst completing the FOCUS programme. She said that he seemed happiest when he was busy and particularly when given trusted roles in the prison.

69. The following day, 23 February, the man had another appointment with the mental health nurse. The nurse recorded that his mood remained "low" and he continued to complain about disturbed sleep and a poor appetite. He told the nurse that he was benefiting from his sessions and the CBT work he had been given, however, he thought that he also needed to be prescribed antidepressants. The nurse noted that he would discuss this with the doctor and arranged to see him again the following week. Later that day, he discussed him with Prison Doctor A. The doctor wrote a prescription for a daily dose of 15 milligrams (mg) of mirtazepine (an antidepressant) and he was allowed to keep a week's supply in his cell.

70. The prison doctor examined the man the next day, 24 February. He noted that he complained of a dull headache, which might be stress related. He wrote that the man had no nausea or vomiting and did not feel unwell. The doctor prescribed Ibuprofen (for pain relief) and Gaviscon (an antacid, for relief of heartburn and indigestion). He asked that his blood pressure be checked in case it was too high. (This happened on 2 March and was found to be within the normal range.)

71. The man and the mental health nurse met again on 3 March for a routine appointment. The nurse recorded that he was working well with the CBT approach and was developing a better understanding of his thoughts, feelings and behaviours. He wrote that he now had a range of strategies to help deal with his problems, which helped him to feel more positive. The nurse noted that

he still had “good days and bad days” and arranged to see him the following week.

72. On 16 March, a fellow prisoner, and the man’s friend, approached a member of wing staff, Officer A. He said that the man was having “negative thoughts” and was “talking about slashing up” (cutting himself). He told staff that the man felt that “everything was going wrong at the moment”. He said that he had applied for his son’s mother’s telephone number to be added to his list of permitted numbers, but it had not yet been arranged. The officer recorded the prisoner’s concerns in the B wing observation book and spoke to the man to reassure him that staff would help to resolve his concerns the following day. (Each wing in the prison has an observation book. Important information about events and prisoners on the wing should be logged so that staff coming on duty are kept informed.)

73. The prisoner was interviewed as part of the investigation. He said that he and the man had become good friends while living on the same wing. He described him as a quiet man, who liked to chat with his friends. He said that the man did not use drugs or drink ‘hooch’ (illicit alcohol sometimes brewed by prisoners using fruit and food available to them) in prison. He told the investigator that the man had been bullied by another prisoner also living on the wing for a while. He said that this prisoner had bullied several men. He said that he had told staff about the bullying, but that the man had not done so. The prisoner said that the man’s son was “the only thing keeping him going” and so their contact was very important.

74. The man completed the FOCUS programme at the end of February and was given his progress report on 18 March. The report was compiled by all of the course facilitators. He attended 58 of the 59 sessions and “despite being apprehensive about completing the offence specific work” he did “begin to apply the work to his offending behaviour”. The authors of the report noted that although FOCUS had been his first experience of group work, he had adapted well and “relaxed” into the programme. They noted, however, that he had “only just started talking about his offending behaviour and is currently finding this extremely difficult and emotive”. They continued that he “appears to be experiencing a high level of negative emotions when thinking about and discussing his offending” and is “yet to develop coping strategies of his own”. It was noted that he had only been able to talk about his offences against one of his victims. Areas requiring further treatment were identified but the report highlighted his development. Having given him a copy of his report to read, in the light of its content, the keyworker asked wing staff to check on him later.

75. On 31 March, the man had another appointment with the mental health nurse. The nurse noted that he needed advice on lifestyle changes which might help reduce his anxiety, including diet, exercise, relaxation techniques and assertiveness. The entry also mentioned “wing issues” and the nurse was asked about this in interview. He explained that the man had described getting very angry about other prisoners’ behaviour and actions. However, the nurse told the investigator that the man had never complained of being bullied or having any specific problems on the wing.

76. Two weeks later, on 11 April, the man saw the mental health nurse again. He complained of feeling particularly low and mentioned difficulties contacting his son. He again complained of disturbed sleep, a poor appetite and "frequent periods of extreme agitation". The nurse recorded that he would discuss with the doctor whether the dosage of mirtazepine needed to be increased. Prison Doctor B agreed to increase the dose to 30 mg per day on 12 April.

77. The mental health nurse told the investigator that he had not talked to the man in depth about the issue of contact with his son, but knew that it was of some concern to him. He told the nurse that his son was very important, particularly as he was not allowed contact with his other children. The nurse said that he did not go into very much detail, but suggested that he was being prevented contact with his son by his ex-partner.

78. The nurse saw him for a follow up appointment on 14 April. They discussed anger management strategies and his fears for his future, particularly after his release. The nurse recorded that his mood had "slightly improved" but was still variable. This was his last appointment with the nurse. Because of staff shortages in the healthcare department, the nurse was allocated to other duties. This meant that he no longer had the capacity to maintain his caseload. In interview, he explained that most of the work he was doing with the man was CBT "self help" and he seemed keen to carry on the work by himself. In any case, the staff shortages meant that no other mental health nurses had the additional capacity to continue the work with him.

79. It appears that the following five weeks were uneventful with no issues recorded in either his prison or medical file. The man continued to be prescribed antidepressants. However, on 28 May, he asked to see someone from the mental health team. Nurse A responded to his request, telling him that the mental health nurse was not available at the moment. He said that he would contact a member of staff if he needed to talk and she agreed to see him again the following week. (It appears that he did not see anyone from the mental health team prior to his death and, although he applied on 30 June to see the mental health nurse, his application was not received until after he died.)

80. On 2 June, Officer B, the man's new personal officer, noted that he was in "good spirits" because he had been given a job as a wing cleaner. He told the officer that he was happiest when he was busy as it gave him less time to think about his offences. Prisoners interviewed as part of the investigation said that he also worked on the servery, filling in for another prisoner who was unwell. They said that he particularly enjoyed this work. However, several mentioned that he complained of not being paid the correct wages. At the investigator's request, prison staff looked into the issue and found that, although some payments had been delayed, he was paid the correct amounts and any discrepancies were resolved. It seems that he made no formal complaints about his wages.

81. The man had an appointment with Prison Doctor B on 25 June. His blood pressure was low and his cholesterol levels were "moderate". No other physical health problems were noted in the medical record. The doctor recorded that the

mirtazepine was helping to reduce his levels of anxiety and insomnia. He noted that the next step was to help him stop smoking.

82. On four occasions during June 2010, staff responsible for monitoring the man's telephone calls raised concerns that he was speaking to his son despite being subject to restrictions. The information was recorded on four separate Security Information Reports (SIRs). (SIRs are completed by prison staff who are concerned about or know of activities which potentially compromise the security of the establishment, the safety of prisoners or members of the public. SIRs are initially dealt with by the Security Department who decide on the appropriate action to take.)

29 June

83. As a result of the SIRs, the Public Protection Liaison Officer went to see the man on 29 June. The officer was interviewed as part of the investigation and he explained that his role is to monitor those prisoners subject to public protection measures and make sure that they understand the procedures involved. The officer is responsible for checking whether arriving prisoners have the necessary clearance to contact, for example, members of their family. Where clearance has not been given, he can help the prisoner to apply for contact.

84. The officer told the investigator that he would have met the man when he first arrived at the prison in July 2009, because he was subject to public protection measures. However, no record of such contact was contained in the documents provided by the prison. The officer recalled that when the man arrived at Full Sutton he told the officer that he did not have contact with his son, but wanted to establish it. It appears that no further action was taken and the officer did not know the reason why.

85. In interview, the officer explained that on 29 June, he arranged to speak to the man at the request of staff in the Security Department. He said that prior to meeting him he had checked the relevant files to see whether any clearances were in place allowing him to contact his son. None was recorded.

86. During their meeting, the officer said that he explained the situation to the man, who told the officer that he had been allowed contact with his son whilst at Forest Bank. He said that he would check other files to see if the paperwork had been misfiled. He also said that he would telephone Forest Bank to find out if they had any outstanding paperwork that they had not transferred, or if anyone could remember verbally agreeing the contact.

87. However, no one at the prison could recall any such agreement being given and no outstanding paperwork was found. The officer said that the man was clearly upset by the news. He knew that he had been on an ACCT in the past. The officer explained that he tried to make sure that he was "comfortable" with the information he was being given. The officer said that he gave the impression that he understood what he was being told. He said that he would have spoken to B wing staff and considered placing him on an ACCT plan if he had any concerns about his wellbeing. The officer did not record his contact with him in

either the wing observation book or the man's personal prison file nor, it seems, did he inform B wing staff of the conversation he had just had with him.

88. Officer C was working on B wing on 29 June. She saw the man on the landing and thought that he "did not look himself" so she asked him if he was alright. He told her about his meeting with the Public Protection Liaison Officer, saying that he was not allowed contact with his son but did not really understand why. She agreed to contact him for clarification. She telephoned him, and he explained the issue. In interview, she said that the man really wanted to be able to speak to his son once more to explain the situation. She said that he was to be allowed telephone contact with his son on the following Sunday (4 July). Officer C relayed this information to the man who was, she said, "over the moon" with the news. She reassured him that, if the correct steps had not been taken, staff would now "get the ball rolling". She described him as "really chuffed" by this.

89. The officer said that throughout their conversation, the man was "adamant" that he was allowed contact with his son. However, she said that he did not say that he had any physical evidence of this, nor show her any paperwork to that effect.

90. During the interview, the officer said that he seemed quite sure that his ex-partner would allow him contact with his son. She explained:

> "So, he didn't give me the impression that he'd never be able to speak to his son again. I got the impression that he would able to … he seemed to think that, I don't know what's going on with his son, but somewhere along the line it was important that he had contact for his son … everything seemed to revolve around his son. But I got the impression that he did think he would get contact."

91. Officer C said that she had no concerns about the man after their conversation and, had she been worried, she would have opened an ACCT plan. She thought it was important that other staff on the wing were aware of the situation and so she made an entry in the wing observation book and in his file. She also spoke to the wing senior officer.

30 June

92. The Public Protection Liaison Officer returned to see the man on 30 June to update him. He confirmed that Forest Bank had not been able to provide any additional information. He said that, for the time being, the man would not be allowed to speak to his son until the correct procedures had been completed. However, he reiterated that he would be allowed to speak to his son on 4 July to explain the situation. This decision was recorded in his log of contact with the man.

93. During the meeting with the Public Protection Liaison Officer, the man said that he would contact his solicitor and request copies of any relevant paperwork. The officer said that he would ask the Public Protection Unit clerk to send a parental consent form to the man's sister as he also wanted to have contact with his nephew. (The officer had already contacted the man's offender manager in the

community. She had agreed to contact the local social services department to investigate whether contact was allowed. She had confirmed that contact between him and his son should cease in the meantime.)

94. The investigator asked the officer if he thought that the man understood the process that had to be gone through. The officer said that he hoped he had explained everything fully. He said that, clearly, he could not know the final outcome but that he tried to reassure him as much as possible. He explained that his own role was to help him "work towards getting that contact".

95. As noted earlier, a number of prisoners contacted the investigator about the man's death, and they were interviewed as part of the investigation. Most of them knew that his son was very important to him. He spoke to some of his friends on 29 and 30 June about his conversations with the officer. They told the investigator that he was very upset at being told he could not have contact with his son. He told some of them that he had a letter from Forest Bank allowing the contact and that a court order to that effect was also in place. None of the prisoners interviewed saw the letter for themselves. There was no mention of such an order in the files relating to his court hearing or his prison records.

96. The man's close friend said that the man told him that he had tried to show the officer the letter, but the officer had not been interested. He also said that the officer had told him it might take between six months and two years to resolve the issue regarding contacting his son.

97. In interview, the officer was asked whether the man had offered to show him the letter from Forest Bank. The officer said that this had not happened and said that, if the man had such evidence, he would have been pleased to receive it. He also told the investigator that he had not given the man any indication of the probable timescale involved in sorting out contact with his son.

98. Officer C saw the man again on the wing landing on 30 June. She described him as seeming "really happy" and she had no concerns about him.

99. He made three telephone calls on 30 June. As each call was recorded, the investigator was able to listen to the recordings. (Staff are required to listen to prisoners' telephone calls within 24 hours.) At about 11.00am, he rang his sister and told her that the prison was stopping his contact with his son because they did not have the "correct forms". He said that the prison was "taking the piss" and that social services had to be involved in the decision. He told his sister that his son had only recently begun talking to him and that stopping contact would "knock [the son] over". He asked his sister to ring his ex-partner and his solicitor to find out about regaining contact.

100. Shortly after 2.00pm, he telephoned his ex-partner telling her that there was "a problem" with his contact with his son. He said that the correct forms had been completed while he was at Forest Bank but that they needed to be filled in again. He told his ex-partner that his sister had tried to contact her but the ex-partner denied having received any calls or text messages. He asked his ex-partner to contact Full Sutton to ask for the forms to be sent to her, or to ask her solicitor to

do so if she preferred. He said that he would call her again the following day to see what she had decided.

101. Immediately after calling his ex-partner, he rang his sister again. He asked if she had heard anything from the solicitor but she said that she had not been able to speak to anyone yet. He told his sister that he had an appointment with his "other solicitor" on 1 July and would call her afterwards to let her know what they had said. He said that he would be calling his son at the weekend but that he "needed to get it sorted". Throughout the calls, the investigator thought that he appeared focused on finding a solution to the problem. Nothing he said suggested that he was thinking of harming himself.

102. On the evening of 30 June, the man and his close friend spent some time together in the latter's cell. He asked his friend to promise not to change the name of their shared budgerigar. (Although no longer in place, a previous scheme had allowed prisoners at Full Sutton to share the care of a pet bird. Their budgerigar was named after the man's son.) His friend asked him if he was planning to "do something stupid". He did not reply but repeated his request that the bird's name should not be changed. When he left his cell later that evening, his friend said he would see him in the morning (their normal exchange). The man replied "I'll see you" and his friend said that this had played on his mind that evening as it was not the man's usual response. He then went back to his own cell, a single cell, for the night.

103. The friend told the investigator that the man sometimes talked of killing himself and he believed that, one day, he would do so. Neither he, nor other prisoners who described his behaviour as a little unusual in the days before his death, raised any concerns with staff. As a Listener himself, the man was aware of the support systems in place for prisoners and he had spoken to several Listeners (some in their capacity as a Listener and some as friends) after his conversations with the Public Protection Liaison Officer.

104. Officer D and Operational Support Grade (OSG) A were on duty on B wing overnight on 30 June. (OSG staff are not required to undertake the same duties as officers and receive less intensive training.) The officer was interviewed as part of the investigation and told the investigator that he normally arrives on the wing at about 7.00pm, although the night shift does not officially begin until 8.30pm. He explained that night staff receive a briefing about the day's events from the wing senior officer and any other staff on duty. In addition a handover sheet is completed by the senior officer on duty which records any important information for night staff. He explained that the night staff must sign this handover sheet to confirm that they have read it. They should also read the wing observation book and familiarise themselves with any open ACCT plans. The officer said that, having received the handover, he walks around the wing and checks that each cell door is secure and that the cell contains the right prisoner (this process is known as the roll check). Having checked all of the cells on B wing, he informed the night orderly officer (the most senior officer on duty and responsible for managing the prison at night) and the control room that his roll is correct.

105. The officer explained that, after the roll check has been completed, prisoners are not checked during the night unless they are category A, on an ACCT plan or there are instructions to check them for any other reason. The man, like the majority of prisoners on the wing, did not meet any of those criteria and so he was not checked between the last roll call at about 7.30pm and the first roll check the next morning at about 6.30am. The officer said that he had read Officer C's entry in the wing observation book on 29 June about the man but that he had no reason to check him during the night. When checked at 7.30pm, the officer recalled that he was sitting at his desk writing and that he "appeared fine".

106. The officer explained that each cell at Full Sutton is fitted with an emergency bell. Prisoners can use this bell to alert staff attention. He said that, if a cell bell is pressed, a member of staff must go to the cell and speak to the prisoner. The bell can only be switched off outside the cell. The officer said that prisoners may use the bell if they want to speak to a member of staff or if they want access to Listeners or the Samaritans telephone. (Each wing at Full Sutton is equipped with a cordless telephone which allows direct access to the Samaritans' telephone helpline. The telephone cannot be used to make calls to any other numbers. The cordless nature of the telephone allows for prisoners to call from the privacy of their cell.) The man did not use his cell bell during the night of 30 June.

107. Officer D and OSG A began their roll check sometime after 6.00am. On reaching the man's cell at about 6.40am, the officer opened the observation hatch in the door (a small window in the cell door which allows staff to see into the cell without opening the door). The cell was clearly lit by daylight. The officer saw the man sitting with his back against the rear cell wall, underneath the window, with a ligature around his neck attached to the window bars. The officer told the investigator that he felt sure that he was dead.

108. The officer used his radio to ask the night orderly officer to come to B wing, saying it was an "urgent message" (this is a commonly used term in prisons to indicate an emergency). He explained that he used this term so that other prisoners in cells nearby did not hear what was going on. He asked the OSG to run to the office to telephone the healthcare department and tell the nurse on duty that there was a "code blue" emergency. ("Code blue" indicates that a prisoner is not breathing and helps responding medical staff identify the appropriate equipment to bring to the scene.) He then decided to follow the OSG to the landing office. As they arrived at the office, the senior officer in the control room telephoned to ask whether it was a code blue situation. He confirmed this and so staff in the control room telephoned for an emergency ambulance at 6.45am.

109. The officer then returned to the man's cell. He used his radio again to seek permission to unlock the cell, in line with the local policy. Permission was granted and so the officer used the cell key contained in the sealed pack to unlock the door. (During the night, only the night orderly officer carries general keys. Other staff are provided with a cell key contained in a sealed pouch. If the seal is broken, certain paperwork must be completed. These measures are in place for security reasons in every prison in England and Wales.)

110. Once in the cell, the officer passed his anti-ligature knife (which is specially designed to safely cut through ligatures) to the OSG. The officer lifted the man while the OSG cut the ligature. The officer told the investigator that the man's body was "ice cold". As the two men lowered him to the ground, the Night Orderly Officer, a Developing Prison Service Manager (DPSM), and Nurse B arrived. At this point, the officer and OSG left the cell to continue the roll check of the other prisoners on the wing.

111. The DPSM was interviewed as part of the investigation. He explained that, on hearing the code blue call, he told the Assist Night Orderly Officer, Senior Officer B, to go to B wing while he collected the nurse from the healthcare department. (At night, the duty nurse is locked in the healthcare department and can only move around the prison when accompanied by one of the night orderly officers. This is standard procedure in prisons in England and Wales.) He said that when he and the nurse arrived on the wing, they were not sure which cell they needed to go to. They found the SO in the landing office and he directed them to the cell.

112. The clinical reviewer spoke to Nurse B as part of his inquiries. The nurse explained that he was experienced in resuscitation techniques having previously worked in a hospital accident and emergency department. He had also completed refresher resuscitation training at the prison within the last year. The nurse said that when he arrived at the man's cell, the staff had difficulty laying him on the floor because his body was stiff due to rigor mortis. He tried to find a pulse, but could not.

113. The nurse used the automated external defibrillator (AED – a machine which can restart the heart by giving an electric shock) to see if the man's heart was beating. The machine indicated that there was no electrical output from his heart and so no shock could be delivered. In any case, the nurse and the SO began cardio pulmonary resuscitation (CPR).

114. The ambulance arrived at the prison at 7.10am and the paramedics reached the man's cell shortly after that. They carried out checks which showed that he had died. The on call doctor arrived at the cell at 7.35am and pronounced that he had died.

Contact with the man's family

115. Following the man's death an officer was appointed as the prison's family liaison officer. At about 9.30am on 1 July, the officer telephoned HMP Manchester to ask if staff from there could visit the man's next of kin, his sister, to break the news. She lives in Bolton and Full Sutton staff thought that staff from Manchester would be able to reach her more quickly. After intervention by the Deputy Governor, HMP Liverpool (which is closer to the sister) agreed to assist.

116. A chaplain and a governor, both trained family liaison officers at Liverpool, visited the man's sister later that afternoon. They told her that Full Sutton would help with the costs of his funeral (in line with Prison Service Order 2710 Follow up to a

death in custody). They also arranged for staff from Full Sutton to visit her at home the following Monday.

117. The deputy governor telephoned the man's sister the day after his death and expressed his condolences. On 5 July, the prison liaison officer and a chaplain visited the man's sister and were able to provide more detailed information about the circumstances of her brother's death. They arranged for her to visit the prison and see his cell. The budgerigar which he and his friend had shared was given to his son. Several members of prison staff attended the funeral.

Support for other prisoners

118. All the prisoners at Full Sutton were informed of the man's death by way of a notice from the Governor. The prisoners on open ACCT plans were reviewed which is customary after a death in prison. The prisoners interviewed as part of this investigation said that a memorial service to remember him was held. Some of those interviewed had chosen not to attend when they realised that the prisoner who they alleged was responsible for bullying some other B wing prisoners (including, some said, the man) was there.

119. Generally, the prisoners spoke of receiving sufficient support. The man's friend said that wing staff and members of the chaplaincy team had offered him support. He was also given the chance to visit the man's cell. Some of the prisoners interviewed were Listeners and they said that the Samaritans had visited the prison on 2 July to offer support to the Listeners at Full Sutton.

Support for staff

120. Shortly after the man's death, those staff involved in the immediate response gathered together with the deputy governor for a hot debrief. (Holding a hot debrief is a requirement of Prison Service Order (PSO) 2710. Its purpose is to allow staff involved in responding to a death in custody to talk about what has happened and how they are feeling.) All of the staff interviewed as part of the investigation, including both healthcare and discipline staff, said that they had been well supported by managers and their colleagues. Those who were due to work the night after the man's death were offered the chance to take some time off.

ISSUES

Contact between the man and his son

121. The man told many of his friends in prison that maintaining contact with his son was very important to him. Several told the investigator that they believed this is what kept him going during his sentence. Staff at Full Sutton who had contact with him were also aware that he was very concerned about maintaining contact with his son, the only one of his children he was allowed to contact. However, the nature of his offences meant that he was subject to the tightest of public protection measures. Those measures are clearly set out in the Prison Service Public Protection Manual and involve a multi-agency approach in which the interests of the child are paramount. A prisoner subject to the measures cannot have contact with a specific child unless all of the agencies involved have given their consent. The manual directs that:

> "It is necessary to carry out fully comprehensive risk assessment of the prisoner and a "best interests" assessment for the child in order to decide what, if any, form of contact is appropriate. Contact includes correspondence, telephone calls and visits."

122. When the man was first taken into custody at Forest Bank in 2006 it seems that a member of staff there incorrectly allowed him to contact his son, without having followed the necessary procedures. It is highly regrettable that the then security governor at Forest Bank did not follow the correct procedures at the beginning of his sentence. However, following his conviction in 2007, he was correctly told that he would not be allowed contact with his son unless or until the correct process had been completed. At this stage it seems that he did not apply for contact and so nothing further was done. In addition, at one stage during his sentence, his ex-partner decided that she did not want him to have contact with their son.

123. In June 2010, staff responsible for monitoring the man's telephone calls submitted four SIRs indicating that he was again talking to his son, without the necessary permissions being in place. The Public Protection Liaison Officer was asked to intervene and, on 29 June, he informed him that the contact must stop until the correct procedures had been followed and completed. Sadly, during the night of 30 June, he apparently took his life.

124. While it is not possible to know what was going through the man's mind that night, it seems that the decision to prevent him contacting his son greatly upset him. He told many of his friends on B wing about the decision and said to some that he felt that he had been treated unfairly by the prison. Consequently, the issue has been a focus of this investigation.

125. It is my view that staff at Full Sutton acted appropriately in deciding to formally prevent the man from contacting his son when they realised that the correct permissions were not in place. On the evidence provided to this investigation, I am satisfied that the Public Protection Liaison Officer acted appropriately. He was not in a position to offer the man very much reassurance as the final

decision was not his to make. However, the evidence suggests that he explained the process fully and provided as much information as he could. The telephone conversations that the man had following his meetings with the officer indicate that he understood what he had been told.

126. However, notwithstanding what I have said above, clearly this was unwelcome and upsetting news for him. When a prisoner (who may have little positive to look forward to and will, inevitably, be spending time locked in his cell alone) is given bad news, staff must make sure that necessary steps have been taken to support him. It is always sensible to make sure that all staff who are likely to have contact with such a prisoner are aware that they have received upsetting news. The officer did not make an entry in either the B wing observation book or the man's personal file. Officer C said that, had she not passed him on the landing and noticed that he did not seem himself, she would not have known that he might need additional support. I make the following recommendation:

The Governor should remind all staff to make entries in wing observation books and in prisoner's personal files whenever they have meaningful contact with a prisoner, especially if potentially upsetting news has been broken.

The man's state of mind

127. The man had been given an IPP sentence in 2007. He knew that he would be spending some time in prison. His sentence plan outlined a number of targets he needed to meet before he would be considered for release. While at Forest Bank, he was assessed by healthcare staff and prescribed antidepressants. However, he had stopped taking these several months before he arrived at Full Sutton.

128. Having transferred to Full Sutton, he completed the FOCUS offending behaviour programme. This programme required him to face up to and talk about the offences he had committed. Staff who knew him told the investigator that he clearly struggled with feelings of guilt and remorse. He told staff that he had considered suicide in the past. However, he took pains to reassure them that he would not act on these thoughts because he had hurt his family enough.

129. In February 2010, the man began seeing a mental health nurse regularly. He admitted feeling depressed and having trouble sleeping and eating. On 23 February, he was prescribed antidepressants again and the dosage was raised in April, when he said that he still felt depressed. The clinical reviewer considered the clinical care provided at Full Sutton. I agree with his conclusion that both the man's mental and physical health needs were appropriately met by the prison. He noted that the healthcare department was suffering staff shortages, but concluded that these did not play a part in his death.

130. All the staff interviewed as part of this investigation were familiar with the ACCT support and monitoring procedures and said that they would have placed the man on an ACCT plan had he given any signs of being a risk to himself. The investigator spoke to a number of staff and they all agreed that they were

shocked to learn of his death and that he gave no indication that he might be considering harming himself. The man's close friend said that he thought, one day, he might kill himself. However, neither he nor other prisoners who talked to him in the days before he took his life spoke to staff about any concerns. I think it is also important to recognise that, as a Listener himself, he was well aware of the support mechanisms available to him, had he wanted to access those. In the light of these findings, I conclude that he did not share the level of his distress with staff and so they had no reason to suspect that he would go on to take his life.

Bullying on B wing

131. During the investigation, some of the prisoners interviewed said that the man had been bullied by another prisoner who had been living on B wing. A few said that staff had been aware of the problem. The prisoners generally agreed on the identity of the prisoner alleged to be the bully but did not agree whether the man had been a target or not. The investigator asked prison staff for any information about whether he had been bullied.

132. A governor provided information that the named individual had been monitored under the prison's anti-bullying measures on "a number of previous occasions", including twice in 2010 while living on B wing. The man was not the subject of the allegation on either occasion.

133. The investigator was told that the man made no written complaints that he was being bullied. Staff interviewed as part of the investigation, including both B wing staff and those who had contact with him for other reasons such as the mental health nurse, were asked if he had ever mentioned being bullied. None said that he had ever raised the issue with them. Most of the prisoners interviewed said that there was at least one member of staff that they felt they could approach. Most said that relationships between prisoners and wing staff were quite positive. From the evidence gathered as part of this investigation, I have found nothing to suggest that he raised the issue of bullying with staff. On that basis, I think that he received the appropriate levels of support.

The emergency response

134. At about 6.40am on 1 July, Officer D and OSG A checked the man's cell as part of their routine roll check. The officer who looked through the observation hatch immediately realised that something was wrong and used his radio to alert the prison to an "urgent message". Very shortly afterwards, he confirmed that it was a "code blue" situation with staff in the control room. However, it seems that neither the officer nor the member of control room staff who telephoned confirmed the exact details of the incident, including the cell number. When the DPSM and nurse arrived on B wing a few minutes later, they were not sure which cell they needed to make their way to. In this case, I do not think that any resulting delay impacted on the outcome; however, it may do in another situation. With that in mind I make the following recommendation:

The Governor should remind staff to include all of the necessary information, including the cell number and location, in emergency radio messages.

135. In interview with the clinical reviewer, the nurse explained that although he was quite sure that rigor mortis was present when he arrived at the cell (indicating that the man was dead), he felt obliged to attempt resuscitation anyway. Annex 13A of PSO 2700, Suicide Prevention and Self Harm Management, states that staff should always attempt resuscitation unless there is evidence that "rigor mortis has clearly set in" (the text is underlined in the original document). Attempting resuscitation when rigor mortis is present can be very traumatic for staff involved. It is also not consistent with the principle that the deceased be treated with respect and dignity.

136. Full Sutton's Head of Healthcare told the clinical reviewer that she had tried to introduce a local protocol covering such situations but had not yet been successful. I endorse the clinical reviewer's recommendation.

The Governor and Head of Healthcare should conduct an immediate review of local procedures to ensure that staff are clear of the protocols to follow when rigor mortis is present.

Family liaison

137. The man's sister told the Ombudsman's family liaison officer that it had taken several hours for news of her brother's death to be broken to her. In addition, she said the news was broken by staff from another prison, who were not able to give her much information about the circumstances of her brother's death.

138. PSO 2710, Follow up to deaths in custody, provides guidance about the liaison with bereaved families. According to the PSO, (which contains mandatory instructions printed in italics) prison governors must:

"Arrange notification to the next-of-kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner, giving an accurate factual account of what has happened."

139. The PSO recognises that it is always best for the news to be delivered face to face by a trained family liaison officer from the prison and as quickly as is possible following the death. However, there are some circumstances in which other options might be used, including when the family live some distance from the prison. In such circumstances, governors have the discretion to ask trained staff from another prison which is geographically closer to the family to break the news to them. This can be particularly important if there are fears that another prisoner might contact the family before staff have had the chance to or there may be unreasonable delay in visiting.

140. The man's sister lived some distance from Full Sutton. Given this, staff decided to ask Liverpool to break the news on their behalf, thinking this would be quicker than staff from Full Sutton driving to Bolton. There were some delays in the

process and Liverpool's family liaison officers did not reach her until the afternoon of 1 July. In retrospect, it is likely that Full Sutton staff might have reached her more quickly, but that could not be foreseen at the time. I think the decision to ask Liverpool staff to break the news was reasonable and preferable to the delay which would have been caused by Full Sutton travelling to the family home.

141. An unfortunate outcome of having another prison break the news is that they will not be in a position to answer many of the family's likely questions. I appreciate that this must have been very difficult for the man's sister – and it is not ideal. However, I am pleased that the Deputy Governor telephoned her on 2 July and that staff from Full Sutton visited on 5 July.

CONCLUSION

142. In 2007, the man was convicted of sexual offences against children, including members of his family. He was given an IPP sentence and knew that he would be spending at least seven years in prison. Because of the nature of his offences, he was subject to public protection measures which prevented him from contacting his children unless rigorous risk assessments had been completed. Although he was not in any contact with most of his children, he had, while in prison, been allowed to have irregular contact with his youngest son, even though the correct procedures had not been followed. He told friends and staff that contact with his son was very important to him and I can well believe that this was the case.

143. He transferred to Full Sutton in July 2009. Part of the requirements of his sentence was that he should complete relevant offending behaviour programmes. He completed one such programme while at Full Sutton. The programme encouraged him to think about the offences he had committed and he told staff that he felt guilty and remorseful about what he had done. Other investigations of prison suicides have found that such programmes can be distressing for prisoners. At various times during his sentence, he complained of depression and was prescribed medication. It seems that he had made two earlier attempts on his life, although staff were reassured by his denials of suicidal thoughts and his statements that he would never want to inflict any more pain on his family.

144. Staff at Full Sutton realised that he was speaking to his son on the telephone and warned him that he should not be because the necessary public protection procedures had not been completed. Eventually, on 29 June 2010, he was told that he would be prevented from telephoning his son until the risk assessments had been carried out. He was clearly upset by the news but appeared to understand the process. He gave no indication to staff that he was vulnerable or a risk to himself. Although he talked to fellow prisoners, none of them shared any concerns with staff. Unusually he talked to a close friend about his wishes for the name of the shared budgerigar but again this was not reported to staff. Soon after he apparently took his life.

145. The investigation has found that staff at Full Sutton followed the correct procedures in stopping him from contacting his son. However, staff working on B wing (where he lived) were not made aware that he had been given bad news and I make one recommendation as a result. However, I do not think that, even if they had been aware, his behaviour would have led them to take any further action.

146. It seems that the man hid his true feelings well. I do not think that his death was foreseeable or, for that reason, preventable.

RECOMMENDATIONS

NOMS accepted all three of the recommendations made. The detailed response is included in italics below each recommendation.

1. The Governor should remind all staff to make entries in wing observation books and in prisoner's personal files whenever they have meaningful contact with a prisoner, especially if potentially upsetting news has been broken.

   Staff information Notice to be published reminding all staff to make entries in wing observation books and in prisoner's personal files whenever they have meaningful contact with a prisoner, especially if potentially upsetting news has been broken.

   Also to be raised as an agenda item for the suicide prevention and residential meeting for April.

2. The Governor should remind staff to include all of the necessary information, including the cell number and location, in emergency radio messages.

   Staff Information Notice to be published reminding staff of the Urgent Message procedure.

3. The Governor and Head of Healthcare should conduct an immediate review of local procedures to ensure that staff are clear of the protocols to follow when rigor mortis is present.

   Staff Information Notice to be published reminding staff of PSO 2700 annex 13A action following self harm-emergency procedures, Hanging para 5.(if not breathing and or no pulse, clear airway and attempt resuscitation…unless rigor mortis has clearly set in.

   Also to be raised as an agenda item for the suicide prevention and residential meeting for April 2011.

   Healthcare staff to be briefed by Healthcare managers of their responsibilities under PSO 2700-13A-para 5.