Investigation into the circumstances surrounding the death of a man at HMP Birmingham in August 2008

Report by the Prisons and Probation Ombudsman for England and Wales

December 2008

The man died, apparently at his own hand, in August 2008. He was found hanging in his cell at HMP Birmingham. He had been remanded into custody and was awaiting sentence. My investigation team (consisting of one of my senior investigators and one of my family liaison officers) join with me in offering our sincere condolences to the man's family and friends for their loss.

My report shows that the man had been thinking about and planning his death, including arrangements for after he died, for at least four months. Although he regularly talked about killing himself to a few of his closest peer group, they did not take him seriously and so did not alert prison staff. He closely guarded his true feelings from prison staff and, instead of causing concern, presented as someone who had settled reasonably well into prison life.

I wish to thank the Governor of Birmingham for making the necessary facilities and information available to my investigator, and for the assistance of the prison's liaison officer. In the course of the investigation, I asked for a clinical review to be carried out into the care and treatment the man received in custody. I am grateful to the appointed doctor for his assistance in providing this review.

Since taking over responsibility for investigating all deaths in prisons in April 2004, there have been five apparently self-inflicted deaths at Birmingham (including that of the man who is the subject of this report), nine from natural causes, one homicide and one death that was drug related. I have not identified any similarities between the circumstances surrounding the man's death and my other investigations.

I have been pleased to learn from my investigator that prisoners at Birmingham feel the staff there are approachable and helpful. Additionally, I am gratified to report that the man's family feel that their contact with the prison has been excellent, especially the support they received from the prison's own family liaison officer. My report makes just one recommendation for the Primary Care Trust. I have also asked the Governor to share with his staff my commendation for the way the follow-up to the sad and unexpected death of the man was managed.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman **December 2008**

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SUMMARY

In February 2008, the man was remanded into custody having been charged with arson and criminal damage. The clinical review shows that he had a complex medical condition that was treated appropriately in both the community and in prison.

The man appeared to settle in reasonably well to prison life. However, although he often spoke to prisoners about wanting to end his life, it was not something that they took seriously. He gave no indications to prison staff about how he was feeling and they had no concerns for his safety.

On 4 August 2008, during the early morning roll check, the officer checking the man's cell could not see him or obtain any response to his calls. The officer summoned assistance, and when staff entered the cell they found him screened from view by a blanket hanging from the bed frame.

Urgent medical assistance was requested and resuscitation procedures started. In his report the clinical reviewer comments on the resuscitation attempts, saying that they were carried out correctly.

It was only after the man was found dead that the true extent of his feelings and plans were known. He had made numerous notes about what he wanted and left them and letters for his family in his cell.

THE INVESTIGATION PROCESS

1. Once my office had been notified of the man's death, the investigation was allocated to one of my senior investigators. He contacted HMP Birmingham's deputy governor and obtained a brief summary of events from him. My investigator agreed to travel to the prison on 11 August 2008 for the purpose of opening the investigation.

2. On 11 August, my investigator and one of my Assistant Ombudsmen, met the Governor. Also at the meeting were the director of healthcare, a representative of the Prison Officers' Association, the chairman of the local Independent Monitoring Board (IMB), the deputy chairman of the IMB, The prison's family liaison officer and the prison's designated liaison officer with my officer.

3. Following any death in prison, I publish a notice to staff and prisoners inviting anyone with information and who wishes to contact me to make themselves known. Three prisoners contacted my investigator and have contributed towards my investigation.

4. On 28 August, one of my family liaison officers telephoned a family friend who was acting on behalf of the man's next of kin. My family liaison officer explained my role and offered the man's family the opportunity to meet her and the investigator. The purpose of offering the meeting was so that his family could contribute towards my report and propose any questions they would like me to address.

5. The family's representative decided that he did not require a visit, but did have one question and asked to see the investigation report. He said he was aware of a number of letters being found in the man's cell and believed they were final notes to named members of his family. He asked the FLO and investigator to try and obtain them, or copies, for him. My investigator asked the prison's liaison officer if there were any letters found in the cell. The liaison officer confirmed that a number of letters were taken away by police and were now in the possession of HM Coroner. My investigator contacted the Coroner's office for advice and was told that the man's family should write to the Coroner to request copies of the letters, or to be given the opportunity to view them. This information was then passed to the family's representative.

6. The family's representative told my family liaison officer that the prison had offered assistance with the man's funeral expenses. Additionally, he said the contact with the prison since the death had been "marvellous". In particular, he praised the help of the prison's family liaison officer.

7. The following month, on 2 September 2008, my investigator returned to the prison to begin the investigation and interviews. Two days later, my deputy ombudsman visited the prison on a liaison visit with the Governor. At the same time, my investigator, who was still at the prison, took the opportunity to invite my deputy ombudsman to a meeting that he had arranged with the

clinical reviewer, and the coroner's officer. The purpose of the meeting with the clinical reviewer was to discuss the range of his report. The meeting with the coroner's officer was arranged to discuss the investigation process and to view the letters found in the man's cell. (The letters were in the main simple messages to members of his family.) I am grateful to the coroner's officer for her assistance.

8. Before leaving the prison that evening, the investigator met the deputy governor and the prisons family liaison officer to give feedback about the progress of the investigation. At that point, there was nothing that had been identified which would lead me to make any recommendations. The investigator told the deputy governor that prisoners and prison staff had cooperated fully with my investigation and that a number of them had been shocked by the man's death. He also told the deputy governor that he had received positive comments from prisoners that the majority of staff were regarded as approachable and helpful.

9. My investigator added that prison staff had said they had felt well supported immediately after, and since, the death of the man. They had all confirmed that they had been invited to attend a critical incident de-brief, and welcomed the opportunity to discuss how they felt at the time of the death.

10. On 23 October, my investigator returned to the prison to complete his interviews. Unfortunately, the investigator was unable to interview the nurse as she was on long term leave and out of the country. However, he has had access to her statement and her police interview, which has helped clarify what immediate medical care was given when the man was found.

11. Before publishing my final report, I issue it in draft to interested parties and ask them to check it for any factual inaccuracies. On 10 October, the Prison Service wrote to me and pointed out that the spelling of the nurse's name was wrong and confirmed what it should be. I have corrected this error. There were no further comments relating to the report, other than to acknowledge that the one recommendation, referred to the Primary Care Trust (PCT).

12. On 17 December, my FLO confirmed with the man's family that they were content with my report. However, they did express concern that letters found in his cell had not been released to them. My FLO advised them to speak to the Coroner's officer, as it is not something that I can deal with.

13. At the time of issuing my final report, I have not been contacted by the PCT regarding the recommendation.

THE MAN

14. Although the man had not been to prison before, he was known to the police and courts. He first came to the attention of the courts in May 2007 when he was found guilty of failing to provide a specimen of breath for analysis. He was given a fine and banned from driving for six months.

15. He next appeared in court in November 2007 after driving a vehicle with excess alcohol, having no insurance, driving whilst disqualified and obstructing a constable. Once again he was given a fine, and in addition a 12 month community service order.

16. In January 2008, the man appeared in court again, charged with driving whilst disqualified and having no insurance. This time he was given a five month prison sentence, suspended for 18 months. He was also fined and disqualified from driving for three years.

17. One month later, in February, the man was remanded into custody having been charged with arson and criminal damage. At that time he was 62 years of age and experiencing prison for the first time.

18. In order to build up a picture of the man while he was in custody, my investigator has spoken both to three prisoners and to prison staff. The first of the prisoners told my investigator that the man often talked to him about his family and his life. He added that the man used to worry about his sister, but the prisoner did not know what was concerning him.

19. The prisoner said the man was worried about the length of sentence he would receive, which he expected to be between ten and 15 years. He often told him that he could not deal with such a lengthy sentence at his age, and wanted to die. But he would then add that he did not “have the guts” to carry it through.

20. A second prisoner told my investigator that the man often talked about his sister, and would become visibly upset whenever he did. The man told him that he had never left his sister before, and the second prisoner believes this was the reason for him being upset.

21. The second prisoner said the man talked regularly about killing himself, citing the expected length of sentence as the main reason. He also told the second prisoner that he did not want to live any longer because he had cancer and was diabetic. However, as with the first prisoner, the man told him that he did not have “the guts” to kill himself.

22. A third prisoner said that the man never spoke to him about ending his life. Had he done so, he felt confident that he could approach prison staff and they would have dealt with it. He described prison staff as helpful and caring and said that they were as shocked as prisoners when the man died. The third

prisoner said no one could have suspected what it was that the man was planning to do.

23. The officer's colleague told my investigator that the man often spoke to him about his family, especially his sister. He had told the officer's colleague that he did not know what he would do if his sister was not around. The officer said the man always looked forward to receiving a visit from his sister and recalled an occasion when his sister did not arrive as planned. Seeing that he was anxious, he had allowed him to telephone his sister and ensure that she was okay. After speaking to her, the man had thanked him for allowing the call and was said to be noticeably relieved.

24. The man had told the officer's colleague that he was an antiques dealer and said he had travelled around the world. My investigator asked the officer if the man had ever talked about killing himself, or had caused him concern. He replied that he had not.

25. The officer's colleague said the man was "openly gay" and would tell everyone. He told the investigator that the man once got into difficulties with another prisoner who had objected to his behaviour. Although nothing more came of it, prison staff spoke to the man about his behaviour and lifestyle and felt it appropriate to recommend his allocation to the High Dependency Unit (HDU). After being assessed as suitable, the man moved to the HDU where he appeared settled.

26. According to the officer's colleague, the man had said that he was innocent of the charges against him but had pleaded guilty on the advice of his solicitor. He said he had been advised that this would help him receive a lighter sentence.

HMP BIRMINGHAM

27. HMP Birmingham is situated in the Winson Green area of the city. It is a category B local prison, holding convicted and unconvicted adult males. It serves the Crown Courts of Birmingham, Stafford and Wolverhampton. Additionally it serves the magistrates courts surrounding the city of Birmingham.

28. The prison was built in 1849. In 2002, additional accommodation was built and provided a further 450 prison places, taking the operational capacity to 1,450 beds. On 4 August 2008, the prison roll was 1,445.

Assessment, Care in Custody and Teamwork (ACCT)

29. ACCT requires staff to identify any concerns, take action, and document those actions for prisoners identified as at risk of suicide or self-harm. The ACCT document should be available to all staff where the prisoner is located. Within 24 hours of the document being opened, the at-risk prisoner will be seen by an assessor and have a case review meeting. The meeting draws up a care and management plan, known as a CAREMAP, and a member of staff is nominated as the case manager. Wing managers take on the role of case manager, oversee the management of the ACCT document and attend case reviews.

First Reception Health Screen

30. The first reception health screen document is the national screening tool used by the Prison Service. It is designed to highlight any medical or mental health issues with new prisoners.

Healthcare

31. Healthcare at HMP Birmingham is provided by the local PCT. It deals with the primary healthcare and contracts Birmingham and Solihull Mental Health Trust to provide mental healthcare services within the prison. Additionally, the Mental Health Trust provides the staff for the 34 bed in patient facility.

High Dependency Unit (HDU)

32. The HDU is situated on C1 landing and provides accommodation for up to 15 prisoners who are located there after being referred and assessed. The criterion for admission to the unit is that prisoners should be regarded as either vulnerable, poor copers in a prison environment or have a history of disruptive behaviour. The unit provides additional medical support for those requiring it. The prison staff employed in the unit have been specially selected to work on HDU. They have also received additional specialist training to help them work with the prisoners.

33. Once a prisoner has been identified as being suitable for the HDC, he is referred to the unit for assessment. If the prisoner is suitable, he is allocated there for a minimum of three months. After this period, the prisoner is reassessed and either remains on the unit or is reallocated to normal accommodation along with a discharge action plan.

34. Following a re-assessment of the prison regime, the Governor has decided to close the unit from October 2008. The reason for its closure is not connected to the man's death and was planned long before this occurred.

Listeners

35. Listeners play an important part in supporting prisoners identified of being at risk of suicide and/or self-harm. They are trained, selected and supported by Samaritans to offer confidential emotional support, 24 hours a day, to fellow prisoners in distress. This is overseen by the prison's own Safer Prisons Officer and by the Samaritans.

36. The Listeners scheme is confidential and any prisoner can ask to speak to a Listener at any time of the day or night. Prisoners can access a Listener easily by asking a member of staff who will then make arrangements for a Listener to speak to them. During the hours that prisoners are locked in their cells, anyone wishing to speak to a Listener can make the request from the night staff on duty.

Police investigations of deaths in custody

37. With all deaths in prison custody, the police are notified by the prison as soon as the death has been discovered. In the first instance, the police treat the area where the person is found as a potential crime scene and, as part of their investigation, note the names of everyone involved and those who have been in contact with the body. Additionally, they note the identity of all those entering and leaving the cordoned area. It is only when the police are satisfied that the death is not suspicious that my investigators may begin their own investigations.

Prison officer grades

38. There are three levels of uniformed prison officer grades. Prison officers are the front-line supervisory staff and, in the majority of cases, prisoners have first and most contact with them.

39. Senior Officers (SOs) are the first grade of managers and act as a reference point for prison officers. SOs are responsible for the day-to-day management of their area, supervising staff and dealing with issues raised by prisoners.

40. Principal Officers (POs) are the highest rank of the uniformed staff. They supervise other uniformed staff and have operational responsibility for the prison.

41. In addition to prison officer grades, there are a group of staff known as Officer Support Grades (OSGs). OSGs wear prison uniform and carry keys but do not carry out the same functions as prison officers. Their role is to support the areas of the prison that have little or no prisoner contact, for example at the gate.

Her Majesty's Chief Inspector of Prisons' Report

42. Between 19 and 23 February 2007, Her Majesty's Chief Inspector of Prisons carried out a five day announced inspection of HMP Birmingham. In the opening paragraph of her report (published in August 2007), she said that Birmingham prison had seen significant improvement over the previous five years. The Chief Inspector said there had been improvements in staff-prisoner relationships, and in safety and decency, and a strong committed management team had succeeded in changing both the culture of, and outcomes in, the prison.

43. Her Majesty's Chief Inspector of Prisons added that the inspection had found that procedures and support for prisoners in their first days in custody, and support for vulnerable prisoners, had been affected by the prison having to take in extra numbers. The inspection team found inadequate entries and plans in the documentation for the support of potentially suicidal prisoners. However, it was also noted that there was evidence of support for individual prisoners. Her Majesty's Chief Inspector of Prisons added that she did not believe the prison to be unsafe, but felt that urgent attention should be given to procedures.

44. In the final paragraph of her introduction, Her Majesty's Chief Inspector of Prisons said that overall the inspection had resulted in a disappointing report as the prison was suffering from the many pressures of overcrowding. She went on to say that it was credit to staff and managers that the prison remained a much better place than it had been in 2000 and that the scale of that task should not be underestimated.

Independent Monitoring Board (IMB)

45. Each prison has an Independent Monitoring Board (IMB) whose role is to monitor the prison and report any concerns that they have about the way prisoners are treated. Board members are able to visit any area of the prison at any time and have direct access to any prisoner who they wish to see, or who requests to see them. The Board holds regular meetings in the prison, with the Governor attending for part of the meeting. The Board produces an annual report that is submitted to the Secretary of State for Justice.

46. In their 2007 annual report, the Board said that Listeners played an important role in the prison, noting that there was an average of 22 Listeners available at any time. They said that there had been three deaths at the prison during the reporting year, one being from natural causes, a second suspected as being from natural causes, and the third being a murder.

47. The Board reported the ACCT system continued to operate throughout the prison and that the majority of staff had received ACCT training. They noted that, during the reporting year, 688 ACCT documents had been opened and that there had been 581 self harm incidents, of which 28 had led to hospital treatment being required. The Board compared the figures to the previous year, when 302 self harm incidents were recorded, of which 39 were noted as being serious.

48. The man, the IMB Chairman concluded the Board's 32 page report by thanking the Governors, staff and prisoners for their friendly and accommodating assistance throughout the year. The Board paid particular thanks to the prison for its hard work in what they said were "particularly difficult conditions".

FINDINGS

49. The man's medical notes show that, on 13 February 2008, he was discharged from hospital after suffering a suspected heart attack some days earlier. The clinical reviewer does not say if the man was issued with any prescribed medication. However, he does report that he was not discharged from hospital with any notes. The next day (14 February), he was remanded into custody after appearing at Birmingham Magistrates Court, having been charged with arson and criminal damage.

50. The clinical reviewer writes that the First Reception Health Screening, completed on the man's arrival into prison, notes that he had a history of heart disease including a triple coronary bypass operation six years earlier. Also recorded was that he had been diagnosed with a complex medical issue and had told staff that he had harmed himself about forty years earlier. The clinical reviewer adds that there were no thoughts of self harm mentioned at that point and that a full mental health screening had taken place.

51. On 19 March, the man was taken to the Magistrates Court. He had been charged on a previous occasion, prior to being imprisoned, with causing "harassment alarm distress, failure to surrender to police or court bail and failing to answer to court/police bail as soon as practicable". At court, he received a two year conditional discharge.

52. Nine days later (28 March), the man returned to the Magistrates Court in relation to the arson charge. On this occasion, he was committed to the Crown Court for a plea and directions hearing, which was scheduled for 12 May. He was remanded back into custody.

53. According to the clinical review, the man next accessed medical treatment when he saw a doctor on 25 April as he had been diagnosed as having Type 2 diabetes.

54. The medical record shows that on 21 June, the man was transferred to hospital as an emergency patient after collapsing. (the clinical reviewer says in his report that the date was 2 July - my investigator has confirmed with the prison healthcare department that it was in fact 21 June.) The reason for the admission was that the man had collapsed when collecting his medication that morning. The nurse making an entry in his medical record wrote that he appeared pale, drowsy and poorly orientated to time and place.

55. The clinical reviewer says that, when measured before leaving for hospital, the man's blood pressure (BP) was low at 74/41, as was his heart beat (HB) at 46 per minute. He goes on to say that there was no discharge summary from the Accident and Emergency Department and no diagnosis in his medical notes. My investigator asked a doctor at the prison what the normal range would be for someone of this man's age. He was told that the expected range is BP140/80-90, with a HB of 70.

56. On 23 July, the man saw one of the prison doctors. The clinical reviewer states that the prison doctor had noted that the man was low in mood and that anti-depressant medication (which had been prescribed before he was remanded into custody) was to be increased. Additionally, the prison doctor noted that the man made good eye contact and had no thoughts of self harm.

57. The following month on 2 August, whilst in the prison healthcare day centre, the man asked a fellow prisoner if he knew how he could kill himself. The prisoner told him that he did not know. At interview, the prisoner said he did not ask the man what he was intending to do. It was something that he often spoke about and he did not think anything of the conversation.

58. A second prisoner, who was also in the day centre, said the man had been upset following a visit with his sister earlier in the week. He said he did not know why he was upset. He and the man had been in an art class and he told my investigator about a picture that the man had completed shortly before he died. The painting, which my investigator recovered from the art classroom, is titled “Life as a Showman”. It has the words “The end” painted onto it. It is not known what he meant by this. (My investigator made the Coroner’s Officer aware of the painting at his meeting with her at the prison.)

59. The next day (3 August), the man received a social visit from two men. The visit went ahead as normal, and as far as can be ascertained there was nothing unusual about either it or his behaviour.

60. Once the afternoon association period ended, the evening meal was served after which the prisoners were locked up for the night. They were not due to be unlocked again until about 8.00am the following morning. A few seconds before being locked up, the man said to a third prisoner that he would be “leaving feet first”. Having heard him saying similar things many times before, the prisoner thought no more of it and was not concerned for his safety.

61. The third prisoner had also seen the man that afternoon. He told my investigator that there was nothing unusual about his behaviour and that he had no reason to be concerned about him.

62. An officer was on duty in C wing in the evening when the OSG arrived to begin his night shift. The officer told the OSG that the wing had been quiet all day and there was nothing of significance to hand over to him. In interview, he said that, before leaving the wing at the end of his shift, the OSG carried out a wing roll check.

63. The OSG told my investigator that in order to check the wing roll he first of all opens the cell door observation panel and then looks inside. He said he is required to see each prisoner and ensure they are there and alive, adding that only when he is satisfied does he confirm the roll as being correct.

64. The OSG said he had completed the roll check by about 8.50pm. He told my investigator that he remembered seeing the man sitting on his bed watching television. He said the man did not speak or acknowledge him. My

investigator asked the OSG when the next roll check would take place. He replied that, unless he was required to carry out more frequent observations on individual prisoners, he would next see them at 5.00am the following morning. The OSG told my investigator that the man was not on any special watch arrangements and therefore he was not expected to check him again until the morning roll check.

4 August

65. At about 5.00am, the OSG began the morning roll check, starting on the top landing. In interview, the OSG said that it usually took longer to complete the morning roll check than the evening check as the cells were often dark, and prisoners sometimes slept underneath their blankets which made observation difficult. He said if he was unable to see the prisoner he would knock on the cell door and gain a response from the occupant. If he was still unable to obtain a response, he would ask the night manager for assistance.

66. When the OSG arrived at the man's cell (C1:23), he carried out his usual method for checking the roll but he could not see him, or gain any response from him. He said he could see a blanket draped over the far end of the top bunk, which obscured his view of the toilet area. As he could not obtain a response, the OSG went to the centre, where he knew the assistant night manager and officers were based, and asked for assistance. (The centre is a term derived from the design of the Victorian prisons, where the wings lead off from one central point, i.e. the centre.)

67. Two officers were at the centre when the OSG arrived from the HDU and asked for assistance. One officer said the OSG told them that he could not obtain a response from the man's cell and asked them to take a look. The officer said that they went immediately to the cell (it is only a short distance from where they were at the time).

68. When the officers looked into the cell through the door observation panel, they also saw that a blanket had been draped over the end of the top bunk. The officers banged on the cell door, and called out the man's name, but could not obtain a response. At the same time, the OSG, realising that something was wrong, used his prison radio and asked the SO to attend. The OSG told my investigator that the SO was there within a few seconds, quickly followed by an officer colleague.

69. The officer said that when the SO arrived, he also tried to obtain a response. When he could not, he unlocked the door and he and the officers went in. The officer said that, when they looked into the area shielded by the blanket, they saw that the man was hanging by a ligature made from a torn bed sheet. The sheet had been attached to the bed head rail of the top bunk. He said he was in a kneeling position, with his knees raised slightly off the ground and his legs behind him. The officer said the man's ears and hands were blue and his arms were by his side.

70. The officer took hold of the man's body, which he said was cold, and supported him while the SO cut the ligature. As soon as the ligature was removed, they placed him onto the cell floor and checked for any signs of life. They were unable to detect any. However, in his evidence, the SO differs with the officer's account and says they did not check for signs of life as he could see that the man was dead.

71. At the same time as this was happening, the nurse arrived. In her written statement, she said that when she arrived at the man's cell she saw him on the floor, lying on his back. She called out his name but did not obtain a response. The nurse also noted that his chest was not moving up and down and there was no pulse. Additionally, the nurse noted that his skin appeared pale and "slightly cold".

72. After carrying out her own checks, the nurse started to administer cardio pulmonary resuscitation (CPR) at a rate of 30 compressions to two breaths, which is the correct ratio. The nurse asked the officer and his colleague to go to the healthcare office on B wing, which is a short distance away from C1, to collect a defibrillator and oxygen. (A defibrillator can restart the heart in some cases of cardiac arrest by giving an electric shock. It detects the electrical activity in the heart and gives automated instructions to the rescuer on what to do.)

73. It took the officers a few seconds to collect the equipment and, when they returned, the nurse attached the defibrillator pads to the man's chest. The automated defibrillator instructed the nurse to continue with CPR which she did. It did not advise her to shock, which means his heart had no beat.

74. The officer's colleague assisted the nurse with chest compressions. He said at interview that the man's hands were blue but that his body was warm. He said the nurse worked very hard to try and resuscitate him.

75. In the meantime, and in line with the local contingency plans, an ambulance had been requested. The prison radio log shows that the ambulance was requested via 999 at 5.40am and arrived at 5.53am. It was followed three minutes later by an emergency response vehicle.

76. In her written statement, the nurse noted that paramedics arrived at the man's cell at 5.57am. She said the paramedics connected their own monitoring equipment to him, which immediately confirmed that he had died.

77. The officer's colleague told my investigator that the man had placed his personal possessions tidily on the lower bunk. He said that amongst the items was a sealed envelope which had "please give to my next of kin" written on it. There was also a handwritten message which said "please contact my family".

After the man's death

78. Following the man's death, the deputy governor asked to meet all staff who had been involved. The purpose of the meeting was to de-brief them, understand what had happened and offer support from the prison care team.

79. The deputy governor also arranged for all prisoners being monitored under the Assessment, Care in Custody and Teamwork (ACCT) procedure to be reviewed. (The reason for this is that vulnerable and at risk prisoners can sometimes become anxious and harm themselves and may require additional support from staff or prison Listeners.)

80. Additionally, the Governor asked the Prison Service Area Psychologist to carry out a Critical Incident De-brief at the prison. He offered the de-brief, which he scheduled for a later date (8 September), to any member of staff affected by the man's death. All staff to whom my investigator spoke said they felt well supported by the prison.

81. On 4 September, my investigator met the coroner's officer. The purpose of the meeting was for the investigator to view the letters found in the man's cell after his death. It was clear from the letters that he had been documenting his intentions since at least 1 April 2008, and that he was thinking about and planning his own death and final arrangements. The coroner's officer also took away the painting that the man had completed.

82. My investigator spoke to the prison's Safer Custody Manager and asked if the man had ever asked to speak to a Listener or been monitored under ACCT, the Prison Service's suicide and self harm procedure. The Safer Custody Manager asked a Listener if the man had ever made contact with them, and was told that he had not. Additionally, the Safer Custody Manager confirmed that he had never been monitored under ACCT.

ISSUES

Clinical Review

83. In his report, the clinical reviewer notes that the man was last seen by a doctor on 25 July 2008. Although the prison doctor had recorded that the man had "Low Mood", he added that he was making good eye contact and had no thought of suicide.

84. At the meeting with my investigator on 2 September, the clinical reviewer said that the doctor is an experienced prison doctor. He said that he was satisfied that his medical assessment did not suggest to him that the man should be monitored and supported under the Prison Service's suicide and self harm arrangements. .

85. The clinical reviewer has found that the man had a complex medical history, which in his view may have affected his behaviour. He adds that the man did not exhibit any suicidal ideation to medical staff. The clinical reviewer goes on to say that the man's physical problems appeared to have been managed appropriately, along with attentive medical care. Finally, he notes that the emergency response appeared to be prompt and appropriate, with suitable equipment readily available.

86. However, the clinical reviewer does make one recommendation regarding the man's discharge from hospital and the lack of notes about his medical condition. He suggests that there should be an audit of Acute Trust discharges and procedures.

The Primary Care Trust should consider an audit of Acute Trust discharge summaries and procedures.

CONCLUSION

87. Unfortunately, despite the support mechanisms in place such as Listeners, ACCT and the help of prison staff, the man did not tell anyone, other than fellow prisoners, about his feelings. Although he told other prisoners on numerous occasions that he would kill himself in prison, they did not take him seriously and gave no thought to alerting staff.

88. It is clear from letters found in his cell after his death that the man had had suicidal thoughts for some time. It is also clear that he had managed to conceal his thoughts from prison staff. In fact, he appeared settled and content. It came as a shock to both staff and prisoners that he had died. What is unclear is what was troubling him. Whether it was the perceived length of his likely sentence, being away from his family, or his illness, or something else, cannot now be known.

89. I am satisfied that the man kept his true feelings from prison staff and they were not aware of his intentions. Equally, I am satisfied that, had he done so, there were sufficient systems and resources in place to help and protect him from harming himself. Sadly, he chose not to share his problems with staff at all, or with prisoners in a way that they found credible.

90. I have been pleased to learn from the clinical reviewer that his analysis of the cardiac tracing taken during resuscitation attempts shows that resuscitation procedures were carried out correctly.

91. I have also been pleased by the prison's follow-up actions in respect of its staff and the prisoners in its care. It is also clear that the support given to the bereaved family was sensitive and appropriate. This was all evidence of good practice, and I would be grateful if the Governor could share that finding and my commendation with all his colleagues and staff.

RECOMMENDATIONS

For the Primary Care Trust

1. The Primary Care Trust should consider an audit of Acute Trust discharge summaries and procedures.