Investigation into the circumstances surrounding the death of a man whilst at HMP Manchester in August 2006

Report by the Prisons and Probation Ombudsman for England and Wales

July 2007

This is the report of an investigation into the death of a man who died in hospital in August 2006. He had been found just before midnight on 25 August, with a ligature around his neck, in his cell on the healthcare centre at HMP Manchester. He was 38 years of age.

I would like to offer my own and my colleagues' condolences to the man's mother, family and friends. I hope that my report addresses the concerns they may have.

The investigation into the man's death was carried out on my behalf by one of my investigators. He was assisted by another of my investigators. A clinical review was conducted on behalf of the Primary Care Trust. I would like to thank the Governor and his staff at Manchester for their co-operation and assistance with my investigation.

The man had been in custody for just over one month. He had found it difficult to cope, and hard to come to terms with the crimes that he had allegedly committed. This was probably heightened by the lack of contact with his family who were based abroad. At the time of his death, the man was being monitored under arrangements for prisoners who are thought to be at risk of suicide and self harm.

My report into the man's death makes nine recommendations. These reflect my concerns on a number of matters. Amongst these are the apparent confusion on the part of staff regarding the circumstances in what cells may be entered at night, and the fact that the man was not given the opportunity to contact his mother, or any other family member, whilst he was in prison.

On 1 April 2004, my office took responsibility for investigating all deaths in custody. Since then I have investigated nine apparently self inflicted deaths at HMP Manchester. One of the recommendations in this report is similar to that made in my report into the death of another prisoner at Manchester on 5 November 2005.

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2007**

CONTENTS

SUMMARY

The man was remanded into custody into HMP Manchester on 24 July 2006. He had been charged with two murders. At this time the man was not considered to be a vulnerable prisoner, but as a potential category A prisoner he was placed on E wing. During the reception process, the man was given a prison induction and a health screen by staff from the healthcare centre. It was recorded that he had a previous history of depression, and had been prescribed medication for mental health problems. However, it was noted that he had never tried to harm himself, or had any intention of doing so.

During the man's first night induction, staff recorded that he was a foreign national, and that he had not been given the opportunity to make a phone call to his family during the reception process. After his induction, the man was asked by an officer if he wished for his family to be told of his whereabouts. The man confirmed that he did, and gave the officer the telephone number of his mother in his home country. However, due to confusion amongst staff of the procedures to be followed in allowing category A foreign nationals contact with family overseas, the man was not given access to a telephone to make the call.

On the evening of 26 July, in response to the concerns of another prisoner that the man might take his own life, an Assessment, Care in Custody and Teamwork (ACCT) booklet was opened. The ACCT booklet describes the problems facing a prisoner at risk of self harm and records the support and monitoring they receive over a period of time. The booklet enables the creation and implementation of a plan to give the prisoner support through a period of crisis. On 27 July, the man was seen by a registered mental health nurse. She noted that he was very low in mood, and was experiencing suicidal thoughts. As a consequence of her assessment, the man was immediately moved to the healthcare centre for his own safety and to reduce any risk of self harm.

The man remained on the healthcare centre at Manchester until his death on 26 August. Whilst in the healthcare centre, the man remained on an open ACCT booklet. He was assessed by both mental health nurses and psychiatrists. Staff noted in his healthcare records that he became more settled during his time there and that his mood improved.

The man was found lying on the floor of his cell just before midnight on 25 August. Healthcare staff at the prison administered emergency assistance, and upon the attendance of paramedics the man was taken to the local hospital where attempts to resuscitate him continued. The man was pronounced dead shortly after 1.00am on 26 August.

Although the man's care at Manchester was generally good, my report makes a number of recommendations. I am especially concerned that he had no contact with his family during his time in custody.

THE INVESTIGATION PROCESS

1. Two senior investigators from my office, carried out the investigation into the man's death. Notices were issued to staff and prisoners informing them of the investigation, and inviting them to contact the investigators should they wish.

2. The investigators visited Manchester, and were shown the healthcare centre where the man spent most of his time in the prison and the cell in which he apparently took his life. They met with the Governor as well as representatives of the Independent Monitoring Board and the Police Liaison Officer. They also made themselves known to a representative of the local branch of the Prison Officers' Association. They reviewed the man's prison and health records, in addition to other documentation made available to them, and interviewed a number of staff and prisoners.

3. The Head of Healthcare at HMP Preston, and the Healthcare Manager at HMP Risley, undertook an independent clinical review on behalf of the Primary Care Trust. Their review, which has been annexed to this report, makes three recommendations.

4. My investigator spoke with the DI from the local Police force, who is also acting on behalf of the coroner. The police confirmed that they had no concerns with regard to the circumstances of the man's death. My investigators have also been in contact with the Coroner's office, and a copy of this report will be sent to the Coroner to assist him with his enquiries into the man's death.

5. One of my family liaison officers wrote to the man's family to offer them the opportunity to discuss the investigation and to raise any issues they wished to be considered. I hope that this report addresses the concerns they may have about the circumstances surrounding the man's death.

HMP MANCHESTER

6. HMP Manchester is a local prison accepting men remanded into custody by the courts in the Greater Manchester area. Since 2003, Manchester has been part of the Prison Service's high security estate. The accommodation is in two Victorian radial blocks, with a mix of single and double cells. The smaller of these blocks is colloquially known as the "top prison" and the larger of the blocks the "bottom prison", the healthcare centre being situated between the two. The inner section of E wing has accommodation for 46 men and is where all category A prisoners are held. It was here that the man spent the first few days in custody before being moved to the prison's healthcare centre.

7. Manchester's healthcare centre has an inpatient facility, and contains 44 beds for prisoners with either physical or mental health needs. The healthcare centre contains seven of Manchester's 'safer cells', which have been adapted to remove ligature points. The man was located in cell MX 03. All of the prisoner accommodation in the healthcare centre is located on the first floor.

8. The inpatient unit is staffed by a combination of healthcare and discipline staff, all of whom are employed by the prison. A high priority is placed on communication within the centre. Each patient is given a nursing care plan which identifies his needs, the objectives of the nursing care, and details of how it will be provided. The prison has a Mental Health In Reach team (MHIR), which is part of the Manchester Mental Health and Social Care Trust. It employs specialist psychiatric staff, including a full time psychiatrist.

9. During the night, when prisoners are locked in their cells and the prison is in patrol state, a minimum of one officer and two nurses are on duty in the healthcare centre. During this shift, the nurses are responsible for preparation of the following day's clinics. These duties are completed on the ground floor of the centre. The night duty nurses are responsible for all healthcare emergencies on the centre and throughout the prison.

10. The healthcare centre contains many prisoners considered to be at risk of self harm and on an open ACCT booklet. In response to my draft report Manchester prison point out that the number of prisoners at risk of self harm moves up and down, and is often less than half the number of patients in the healthcare centre. The observation of healthcare inpatients who are on open ACCT documents is shared by nursing and discipline staff, although during the night officers are generally responsible.

11. The last full announced inspection of Manchester by Her Majesty's Chief Inspector of Prisons took place in July 2004. The report says that the inspectors found the prison to be a more stable and purposeful environment than during previous inspections.

KEY FINDINGS

12. The man was received at Manchester on 24 July 2006, after spending a number of days in police custody. The Prisoner Escort Form (PER), a document that accompanies the prisoner and staff on all escorts and provides a chronological record and a communication tool about the prisoner's risks, was completed by staff from Global Solutions Limited (GSL). The form indicated that the man had "mental issues", had been charged with a double murder, had absconded from prison abroad and was violent and a potential escape risk. Staff had also indicated that the man was vulnerable. It was established that the man spoke good English.

13. Later that day, a reception officer at Manchester noted on the PER form that the man was "Not vulnerable after reception interview." During an interview with my investigators the reception officer said that the man was offered protection during the reception process. He said that the man was insistent that he wanted to go onto normal location.

14. The Senior Officer (SO) who has been working in reception at Manchester for the past twelve months, confirmed during interview that just because a prisoner was marked as being vulnerable on the PER form did not automatically mean that he would be treated as a vulnerable prisoner. The reception SO explained that the officer completing the Cell Sharing Risk Assessment (CSRA), a document used to assess a prisoner's risk to other prisoners and to himself, would complete additional paperwork if he believed the prisoner was vulnerable, or if the prisoner had asked for protection. The reception SO said that this paperwork would be given to the duty governor in order that he could make the decision as to whether the prisoner should be treated as vulnerable. If so, the prisoner would then be located in either the segregation unit or the healthcare centre. The man did not ask for protection and so no such consideration was made.

15. The reception officer explained to my investigators that all prisoners entering prison for the first time would be treated in the same way. He said that the man would have been rubbed down by staff, before being photographed and having his fingerprints taken. He said that the man's personal details would have been entered onto the prison's computer system before he was allocated a prison number.

16. The man's personal details were recorded on his F2050 Core Record 'Page 1', a document on which height, weight, offence, distinguishing marks etc., are recorded as well as the details of the prisoner's nominated next of kin. The reception officer told my investigators that it was the responsibility of the escort staff from GSL to complete next of kin details prior to a prisoner entering the establishment, and that officers in reception do not ask prisoners who their next of kin are. I understand that at Manchester the 'Page 1' is always completed by GSL staff, often at court (unless the GSL staff are based outside the Manchester prison catchment area or if a prisoner is a licence revokee, in which case prison staff

complete the form). My investigators read 'Page 1' of the man's record, noting that a number of his personal details, along with the names and contact details of his next of kin, had not been entered, a line having been put through them. Maybe the man didn't want to give these details.

17. When the reception SO noticed the murder charge on the man's warrant, he made contact with the collators department, the unit within the prison that makes decisions about a prisoner's security classification. The reception SO said that they then took the decision that the man should be treated as a potential category A prisoner, one whose escape would be highly dangerous to the public. This was confirmed in the man's security file on 24 July, with a note that he should be treated as a standard risk category A prisoner.

18. After the initial reception process, the man was interviewed by the reception officer and a CSRA was completed. The reception officer recorded that the man was of a low risk of harm to others. The reception officer wrote in the man's wing history sheet:

> "PER marker states vulnerable. This man does not want any protection and agrees to go on normal location. All be it, the Cat A unit."

19. During interview, the reception officer explained that all prisoners would be offered the opportunity to make a telephone call during the reception process, but he believed that there was not the facility in reception to make an international phone call. The reception officer thought that the man, as a potential category A prisoner, might have been restricted in making a phone call until the telephone number he wanted to ring had been given security clearance. The reception SO told my investigators that the only difference between the way a category A prisoner and others were treated was that the man would not have been given the opportunity to make a phone call to a relative or friend whilst in reception.

20. As part of the reception process, the man was interviewed and an initial health screen was conducted by a nurse. Although the man's personal details were not recorded on the health screen, the initial health screen nurse did record the details of the man's doctor and that he had seen a doctor in the last few months for depression. The man told the Initial health screen nurse that he had been on Seroxat, an antidepressant. The initial health screen nurse recorded that the man had no concerns about his physical health, drank socially and had no history of drug abuse. She noted that he had seen a police psychiatrist whilst in police custody, and had been prescribed medication for mental health problems. She noted that he said he had never tried to harm himself, and had no intention of harming himself. The initial health screen nurse recorded on the assessment that no immediate action was required.

21. A member of the escort staff had already completed a Suicide/Self Harm Warning Form. They recorded on the form:

"small marker on police form inside PER – No markers on front of PER – has been fine today."

22. The reception SO told my investigators that staff at Manchester would be alerted to a prisoner's risk of self harm by completion of the form by GSL staff. However, the initial health screen nurse said she could not recall seeing the form during the man's initial health screen. She said that, if she had, she would have indicated on his record whether or not an ACCT document had been opened on him.

23. The initial health screen nurse completed section three of the CSRA, recording that the man was a low risk and that following the self harm assessment no concerns had been raised.

24. The man was also seen by a doctor in the healthcare centre on 24 July. It was recorded that he had a previous history of depression and poor anger management and had been taking 20mgs of paroxetine (the generic drug of Seroxat) for the last two to three weeks. The Doctor also noted that the man denied any suicidal thoughts or that he had previously self harmed. He said that the man made good eye contact but was tearful when interviewed. The medical officer noted that the man needed a follow up appointment during the week and required an appointment with a community psychiatric nurse (CPN).

25. The man was located with other category A prisoners on E wing. An entry in the E wing observation book records that:

"A new cat A received from reception. [the man] is charged with the murder of his girlfriend and her daughter (both killed in a house fire) [The man] has for the moment declined VP [vulnerable prisoner] status."

26. A first night induction programme was completed by an officer who recorded that the man was a foreign national, that he had not been given an opportunity to make a phone call in reception, and did not feel depressed or suicidal. The first night induction officer wrote that the man's first language was not English and he gave a foreign address as his home address. The man told staff that he did not wish his home countries consulate to be informed of his whereabouts, although no reason for this was recorded. The first night induction form also indicated that the man did not want to be kept apart from other prisoners. The first night induction officer entered a record of this on the man's wing history sheets:

"First night induction given. Compact signed. States has no problems at this time. Speaks very good English. [Foreign] national."

27. After his first night induction had been given on E Wing, the man was asked by Officer A if he wished his family to be informed that he was being held at Manchester. The man said he would, and provided the officer with

the name and telephone number of his mother. Officer A noted that the SO on the wing was to call the number. Officer A also recorded that the man was given a full induction and the rules and regime of the unit were explained to him. The man said that he had no problems.

28. Officer B from the induction unit at Manchester explained to my investigators that foreign national prisoners were entitled to one airmail letter but were not allowed a free phone call for their first month in prison. He said that, at the end of this month, prisoners could exchange their four visiting orders for a five minute phone call, but could make as many paid phone calls as they liked using the PIN phone system. (This system stores authorised numbers and prevents prisoners from making unauthorised calls.)

29. On 25 July, an HMP Manchester Custody Plan was opened by the first night induction officer on E wing. Although the man's personal details were entered into the record, no further information was recorded and there is no evidence that a plan was made for the man. On the same day, the man's prisoner spending account was credited with a £3.50 advance, which he spent on items from the canteen (prison shop). My investigators have confirmed that the only money the man had access to during the remainder of his time at Manchester was the 50 pence unemployment pay that was credited to his account on a daily basis. The following day, the man was given a PIN phone card.

30. On 26 July, at 7.30pm, an SO opened an ACCT form. (This is the document used by the Prison Service to monitor and assess those prisoners at risk of self harm.) During interview with my investigators, the SO who opened the ACCT said that the man was very quiet during his time on E wing and confirmed that another prisoner had raised concerns that the man might take his own life. The SO said that, as a consequence, he immediately interviewed the man and opened the ACCT document. He noted that the man had thoughts about killing himself because of his trial that he was very low in mood and was frightened that his offence would become public knowledge. An immediate action plan was raised by the SO who opened the ACCT. The man was to remain in his cell, was to be observed hourly during the night, and the Samaritans phone was to be made available to him. (The Samaritans are a group of volunteers who provide confidential emotional support to those in the community who are experiencing feelings of distress or despair. (In English prisons all prisoners have access to the Samaritans by means of a cordless phone.) It was also noted that his mother's telephone number in his home country had not yet been cleared, and a note was made for the wing SO to authorise the number.

31. At interview, the SO that opened the ACCT explained that, because the man was a category A prisoner, he had to have security clearance on all his phone numbers before they could be put on to the PIN phone system. The SO said that, once the number had been put onto his PIN account, the man would have been able to speak with his family. The SO who

opened the ACCT also told my investigators that, at the time the ACCT was opened and the immediate action plan was raised, the man had not given staff his mother's telephone number.

32. On 27 July, an assessment interview was completed by an ACCT assessor. He noted that the man feared his trial, felt "down" and had lost his appetite. The man had said that he wanted to be "dead forever", but he had no plan to kill himself. The ACCT assessor recorded that the man was unable to contact family on the outside as his phone numbers needed to be submitted for clearance.

33. Later that morning, the ACCT assessor conducted the man's first ACCT review alone. The ACCT assessor wrote that the man was struggling to come to terms with his alleged offence and upcoming trial and was unable to contact anyone due to the non-clearance of his mother's telephone number. The care plan completed by the ACCT assessor recorded two actions and goals. The first was for the man to alleviate his fears and doubts for his upcoming trial by creating a list of fears for his next legal visit. The second goal was to establish contact with his mother, and the clearance of her number was assigned to the wing SO in order that it be completed as soon as possible. Having considered the concerns that the man had raised, the ACCT assessor noted on the ACCT that the next review should take place a week later on 3 August.

34. On 27 July, a Security Information Report (SIR - a document used to collect and collate security information on prisoners) was submitted by Officer C. It recorded that a prisoner had said that the other prisoners on the wing had found out what the nature of the man's alleged offence was, and they were planning to "fill him in".

35. At 2.30pm, the man was seen by a Registered Mental Nurse (RMN). The RMN nurse is a crisis intervention worker who works in conjunction with the Mental Health In-Reach team (MHIRT) at Manchester. The RMN nurse recorded in the on-going record of the ACCT document that the man was:

> "visibly slow, he expressed despair and hopelessness and very fearful. He admitted to feeling overwhelming guilt and that no-one can help him."

Due to her concerns, the RMN nurse decided that a period in the healthcare centre would:

> "…be of benefit to his safety and to reduce any risk of self harm."

The RMN nurse made additional notes in the man's medical record. She recorded that he was very low in mood and was experiencing suicidal thoughts. She said that the man was terrified that his charges might become known to others, and that he would be "better off dead". At this

time, the RMN nurse also completed a Mental State and Risk Assessment Screening of the man.

36. During her interview with my investigators the RMN nurse said she was:

> "extremely alarmed at how thin and frail the man appeared. He looked in quite bad condition physically and instantly that made me feel quite concerned about him. His eye contact was very poor, his posture was very withdrawn. He was extremely uncomfortable in my presence and he seemed to be uncomfortable around anybody."

The RMN nurse also said that she did not feel at risk from the man, sensing that he was at more risk to himself than to anybody else. On learning of his death, she was not surprised, believing that it was his ultimate intention.

37. At 3.55pm, the man was located in cell MX 03 in the healthcare centre. As part of his ACCT plan he was put on an intermittent watch (a process whereby staff observed the man five times an hour at irregular times). At 4.00pm, a nurse completed an initial care plan on the man. The nurse completing the initial care plan noted on the plan that the man was on an open ACCT and, although low in mood, was objective and appeared to be "alright".

38. During the next two days, the man settled into the healthcare centre. Notes made in his medical record say that, although low in mood, the man attended to his personal care and appeared settled. During lunch time on 29 July, he asked staff how he could recover £66.00 from the police which he had in his possession when he was arrested. Later that afternoon, it is recorded that the man had a haircut.

39. In his report to the Coroner of 13 September a doctor, an associate specialist in psychiatry at Manchester, said that he saw the man on 31 July and diagnosed reactive depression with a high suicidal risk. The doctor said that he prescribed a number of antidepressants, including citalopram, olanzapine and zopiclone. He recommended that the man remain on intermittent watch and that he be reviewed daily. The doctor saw the man again the following day where he appeared "not so anxious" but still looked depressed. On 2 August, the doctor noted that the man had slept better but his mood was still depressed.

40. The man's second ACCT case review took place on 3 August. By this time an SO had been appointed the case manager and others attending the review included the Chaplain and a Reviewing Nurse as well as another member of staff. It was recorded that during the review the man remained settled, that he again raised his concern that his mother did not know where he was, and that he had no thoughts of self harm. During his interview with my investigators, the case manager said that the chaplain took on responsibility for looking into the clearance of the man's mother's

telephone number.

41. No change was made to the man's care plan during this review. The case manager told my investigators that the man did not present as someone who was feeling low in mood during the review, seeming quite stable. His next review was scheduled for 17 August.

42. My investigators spoke to the chaplain. He said that he had spoken to staff about approval for the man to phone his family, but had been told that the application was being "processed". He said that the man wanted things "done yesterday" and was very frustrated by the delay. The chaplain said that he visited the man in his cell frequently, and the man attended Bible study classes every Wednesday. He described the man as "withdrawn, concerned and reflective", but said that his demeanour had improved during his stay in healthcare. He had recently opened up during Bible study classes. The chaplain went on to describe the man as "very impulsive" and said he was looking forward to a time when he was released from prison. The chaplain confirmed that he had always been allowed to go into the man's cell for a one to one chat, describing him as very polite and mild mannered.

43. The associate specialist in psychiatry saw the man again on 4 August. He recorded in his Inmate Medical Record (IMR) that he was sleeping better and had no plan to take his life, having thought of doing so only sometimes. On 7 August, the man was seen by a consultant psychiatrist at the prison. The associate specialist in psychiatry saw the man again on 9 August and noted that his verbal contact had improved but that he still felt down. The man remained on an intermittent watch.

44. On 8 August, the man's solicitor wrote to the Governor. The solicitor expressed the man's concern that he had not been given the opportunity to call his mother to make her aware of his current whereabouts, and requested that the man be able to do so at the earliest opportunity.

45. Also on 8 August, the security collator at Manchester sent a standard photocopied letter to the man's mother informing her that her son had requested that her name be added to his list of approved visitors. He did not mention the man's efforts to contact her, nor was any confirmation sought with regard to the approval of the telephone number that the man had given the prison. The man's mother responded to the letter on 16 August. In her reply she made a number of general enquires seeking information with regard to visiting her son and whether she could talk with him on the telephone and, if so, what number she should dial. The man's mother also asked how she could send money to her son. I understand that no response to the man's mother was ever made by the security collator or any one else at Manchester.

46. During a ward round on 10 August, the associate specialist in psychiatry and the consultant psychiatrist noted in his IMR that the man was still feeling low, reporting to them that he had a lot on his mind. It was noted in

his medical record that he was suffering from reactive depression. Later that day, the associate specialist in psychiatry and the consultant psychiatrist completed an inpatient review. The consultant psychiatrist recorded that the man appeared less stressed and more animated.

47. Over the next few days and weeks, notes in the man's ACCT document recorded him as presenting no problems. A number of entries record that he was happy watching TV and speaking with staff.

48. On 15 August, the man's solicitor wrote to the prison again. He said that he had received no response to his previous letter and asked that the matters he had raised be addressed as a matter of urgency.

49. On 17 August, a discipline officer noted in the man's wing history sheet that he had been given two airmail letters for the month.

50. On the same day, the associate specialist in psychiatry undertook a review of the man's mental state. In his report to the Coroner, he said that at the time there had been quite an improvement in the man. The man had good verbal and eye contact, and had denied any thoughts of self harm, saying he was only suicidal at the beginning of his remand period because it was a shock to him.

51. Also on 17 August, the man had another ACCT review, attended by the case manager, a reviewing nurse and the chaplain. The case manager said that, during this review, the man "presented as totally stable". His mood had changed slightly in that:

> "…he was coming across as more settled. More relaxed more upbeat in fact."

The man's level of risk was reduced to low and it was noted that he was:

> "…reasonably settled on this unit, he misses the greater space and interactions with other prisoners which he had whilst resident on the cat A unit. [The man] stresses that he had no intentions whatsoever of self-harming. He has requested to be placed on education; this is being arranged for tomorrow morning."

No new updates were made to the man's care map and the next review was scheduled for 1 September. During his interview with my investigators the nurse who was present at the review, said:

> "[The man] seemed a very steady sort of guy with his mood and with his behaviour, there were no great ups and there were no great downs, he was quiet, he appeared settled and he did not exhibit any outward symptoms that he was going to self harm."

52. On 18 August, the man's solicitor received a response to his earlier letters from the healthcare principal officer (PO). The healthcare PO explained

that the police liaison officer at the establishment had forwarded the man's mother's telephone number to the police officer in charge of the case so that it could be cleared, and that this clearance had not been received back into the prison. He said that in the meantime, the man had been issued with pre-paid air mail letters so that he could correspond with his mother.

53. The healthcare PO said that on receipt of the letter from the man's solicitor, he contacted the police liaison officer at the prison to ask what was happening. He was told that the number had been passed to the police officer in charge of the man's case so that it could be verified. The healthcare PO said that, because it was taking so long for the telephone numbers to be cleared, the man was given some airmail letters in order that he could write to his mother. When asked if he had any previous knowledge of the man's having difficulty in contacting his mother, the healthcare PO said that any problems would have been written in the mans' wing sheets. He said that, if the man or any one else had problems contacting their family, they would come and see staff who would do their best to sort it out for them. However, he said that the man had not raised any concerns with healthcare staff.

54. During his interview, the case manager (who chaired the ACCT reviews on the man) said that he had discussed the possibility of the man's mother coming to Manchester to visit. Given the distances involved, there would be dispensation for her to make a number of visits over a couple of days. However, the case manager could not be sure whether the man's mother's phone number had been cleared by the end of August.

55. On 23 August, the man's solicitor wrote to him as a consequence of queries that the man had raised during recent visits. However, it would appear that the man never received the letter as it did not arrive in the healthcare centre until 29 August, three days after his death. In the letter, the solicitor explained that any phone numbers that the man wished to call needed clearance, and that his mother's number had been forwarded to the relevant officer for clearance. The solicitor also advised the man that he was attempting to ascertain the most appropriate way to have his balances transferred from his bank account into his account at the prison.

56. On the same day, the solicitor also wrote to the healthcare PO to ask when the man's telephone number had been forwarded for clearance and when the clearance was expected. As with the letter written to the man, this letter was not received in the healthcare unit until 29 August.

57. On 24 August, the associate specialist in psychiatry undertook what was to be a final review of the man's mental health. In his report to the Coroner, he notes that the man was, in good spontaneous contact. He talked a little of his time in his home country, recalling how he had been in a psychiatric hospital twice but had been discharged as not suffering from any mental illness.

58. At interview, the associate specialist in psychiatry told my investigators that he had been suspicious of the sudden improvement in the man, though not "overly so" because it was possible that people did improve. The associate specialist in psychiatry said that the man often wanted to talk to his girlfriend. He said that with hindsight he might have meant "talk to her in heaven", but at the time he thought the man was just expressing remorse. The associate specialist in psychiatry said that at no time had he felt that the man was a dangerous or aggressive person or a danger to other people.

59. In the days immediately prior to the man's death notes made by staff in his medical records and ACCT document indicate that he was complying with the regime and sleeping well. Overall, I judge that the ACCT process was followed properly throughout his time in custody.

25 August 2006

60. At 4.15am on 25 August, an officer wrote in the man's medical notes that he had slept overnight and remained on an intermittent watch.

61. The man awoke at about 7.45am. It is recorded in his ACCT booklet that at 8.00am he cleaned out his cell and watched television. Just after 9.00am, he attended his education class, returning to his cell at about 11.30am. The man then slept between about 12.55pm and 1.30pm when he awoke and lay on his bed watching television until about 2.20pm. At about 3.00pm, he went on exercise when he was seen to be sitting in the yard. The man returned to his cell at about 3.45pm and was seen pacing his cell at 4.00pm. Between 4.15pm and 10.45pm, the man watched television, having his evening meal at about 6.00pm. The reviewing nurse said he gave the man his medication some time after 9.00pm. The reviewing nurse recalled that he had a superficial conversation with the man at the time about seeing him in the morning to which the man replied "fine". The ACCT booklet records that the man was asleep at 11.40pm.

62. The discipline officer on duty in healthcare on the evening of 25 August, said that, whilst carrying out one of the five hourly checks on the man at 11.55pm, she noticed he was sitting on the floor of his cell and that he was unresponsive. She told my investigators that he:

> "…was sat on the floor but in a very strange position and he just looked, I don't know how to put it, like he just wasn't moving for me. I immediately dropped the hatch, as I recall and I was banging and shouting his name on the door and then pretty much within seconds I notified the nursing staff."

The discipline officer said she alerted the reviewing nurse and accompanying nurse and recalled that she:

> "…was quite anxious and worried and [the accompanying nurse] came as well and obviously they weren't happy and nobody could get any

response whatsoever, so I just got straight on to the radio then and asked, I think I asked for Oscar 1, and I just said that we needed staff urgently on the healthcare, I can't even remember what I said, but it just seemed like pandemonium really."

63. In her incident report, the discipline officer confirmed that she called for assistance from the night orderly officers, Oscar 1 and Oscar 2, on the radio. The discipline officer said that amongst the first officers to respond were Officer D, Officer E and Officer F, who all attended from the top prison. She said that Officer G arrived with the night orderly officers Oscar 1 and Oscar 2. The discipline officer initially thought that it was Officer E from the top prison who was the first officer to arrive, and that it was he who made the decision to enter the man's cell. However, the discipline officer went on to explain that Officer E had some difficulty in retrieving his cell key from the emergency pouch. She said that, before Officer E had broken into the pouch the night orderly officers had arrived and the cell was unlocked. The discipline officer said that, as soon as the cell was unlocked, the reviewing nurse and the accompanying nurse entered and that she moved a wooden chair from the cell to provide more room.

64. My investigators asked the discipline officer if there was any instruction or procedures to be followed when entering the cell of a category A prisoner during the night. The discipline officer said that there probably was, but could not remember. When asked what factors she had taken into account when considering whether to enter the man's cell, the discipline officer said:

> "Well for me I wasn't going in that cell and I wasn't going to allow either of the nursing staff to go in, until we had got a PO there, no way."

The discipline officer said that she took into consideration the nature of the man's alleged offence when deciding whether or not to allow the nurses to enter the cell. In this instance, she thought this was the best way to deal with things:

> "Because of the fact that he was a cat A and the fact that he was in for a double murder charge and in all the circumstances, at the back of your mind you always think about the hostage thing as well, so I thought that I personally would rather wait until, and it was so quick there was just no time really wasted in the staff getting there, nobody could have got there faster than what they did and nobody could have acted as quick."

65. In her incident report, the accompanying nurse said that she went to the cell along with the reviewing nurse at approximately 11.55pm after hearing the discipline officer's call for assistance. When she looked through the hatch, she saw the man was lying on the floor and he did not respond when his name was called. At that stage, she said they could not see the ligature around the man's neck. The accompanying nurse said that she and the reviewing nurse asked the discipline officer if they could enter the

cell, since their immediate reaction as nurses were to go in. However, she said that the discipline officer told them that the man was a category A prisoner, that it could have been a ploy and he could have been holding a weapon. The accompanying nurse said that, for everyone's safety, the discipline officer called for the night orderly officer immediately.

66. The accompanying nurse then went to the outpatients unit, downstairs in healthcare, to collect the emergency bag which contained all the "first aid equipment that you would need". When she returned to the cell, a number of officers had arrived and the cell door had been opened. She entered the cell and, along with the reviewing nurse, checked for signs of life and started cardio pulmonary resuscitation (CPR). My investigators asked the accompanying nurse why the emergency bag was located downstairs on the unit when prisoners were housed upstairs. She explained that there was now a bag upstairs, but that going to collect the resuscitation bag from downstairs "would have made no difference time wise." The accompanying nurse said that the defibrillator machine was not kept with the emergency bag, but was also downstairs.

67. In his incident report, the reviewing nurse said that he was called to the man's cell at approximately 11.55pm. Upon arrival, he saw the man slumped on the floor between the bed and the television shelf. He said that, whilst the accompanying nurse went to collect the emergency bag, he returned to the office to collect a pair of (ligature) scissors and other equipment before returning to the cell. The accompanying nurse told my investigators that:

> "…it was obvious he had collapsed and to be frank I would say he was obviously dead from what I could see."

On 20 November 2006, the Prison Service introduced a Prison Service Instruction (PSI 32/2006) outlining the arrangements for appropriate staff to be issued with "cut-down tools". These knives are shaped like fish and contain a concealed blade in the mouth section which is designed to allow the user to get underneath a ligature. The action of pushing the knife forward cuts the ligature away from the body. At the time of the man's death, only ligature scissors were available to staff. These were not carried in person but kept in easily accessible places such as wing offices. I understand that, by the end of March 2007, most officers at Manchester will carry the knives.

68. The reviewing nurse said he entered the cell at approximately 12.02am. With the accompanying nurse, he moved the man in order to commence CPR. At this point he noticed the ligature around the man's neck, which he cut away with the scissors. He and the accompanying nurse checked for signs of life and started CPR immediately. The reviewing nurse said that he believed the man was already dead. The ambulance arrived at about 12.15am and the paramedics took the lead in resuscitation. The reviewing nurse said that the man was taken to the ambulance at about

12.30am.

69. The reviewing nurse said that he was unable to enter the man's cell that night without the permission of the discipline officer on duty. He added that, during the night, nurses were not supposed to enter cells without a principal or senior officer being present.

70. In his incident report, the night orderly officer (Oscar 2) said that at approximately midnight he and the night orderly officer (Oscar 1) went to the healthcare centre following a request by radio. (Oscars are the orderly officers who have responsibility for the running of the prison during the night.) He said that, upon arriving at about one minute past midnight he was told by the discipline officer that the man was lying in his cell and was unresponsive. Night orderly officer Oscar 2 said that the discipline officer, Officer E, F and D, as well as the accompanying nurse and reviewing nurse, were in attendance when he arrived, with Officer G arriving immediately after himself. After assessing that the man was in need of immediate medical attention, he unlocked the cell door and entered, closely followed by the reviewing nurse and accompanying nurse. The night orderly officer Oscar 2 said that both nurses started CPR and the reviewing nurse requested that an ambulance be called. The night orderly officer Oscar 2 said that he then withdrew from the cell in order to prepare for the likely escort of the man to hospital. He was accompanied on the subsequent escort by Officers G and F. He said that they left the healthcare centre at 12.45am and arrived at the local hospital at 00.56am. The man was pronounced dead at 1.11am.

71. My investigators asked the night orderly officer Oscar 2 what the procedure was for staff entering cells during an emergency. The night orderly officer Oscar 2 said that any member of staff could enter a cell, adding that is why they have a key. He said that:

> "Staff would obviously be conscious of the fact that he [the man] is a category A prisoner, but they do need sufficient staff to be able to do that, it is a very difficult situation for staff, on the one hand you have got the medical care that the prisoner requires and on the other hand you have got the security of the establishment to consider, and it probably is quite a quandary for staff but as I say I don't think there is any great delay on this occasion."

72. The night orderly officer Oscar 1 said in his incident report that, at about midnight, he and the night orderly officer Oscar 2 responded to an urgent call from the discipline officer to attend the healthcare unit. He said that, upon arriving at the man's cell, Officers D, E, F and the discipline officer, along with the reviewing nurse and accompanying nurse, were in attendance. He was told by the discipline officer that the man appeared to be unconscious in his cell. The night orderly officer Oscar 2 arrived at the cell first, assessed the situation and unlocked the cell door. The night orderly officer Oscar 1 said that the reviewing nurse and the accompanying nurse entered, attending to the man. At three minutes past

midnight, the night orderly officer Oscar 1 requested that an ambulance be called.

73. During interview, the night orderly officer Oscar 1 was asked what he would expect of staff when attending a cell in which a prisoner was seen to be unconscious or not moving. The night orderly officer Oscar 1 said:

> "The instructions I believe are pretty clear that staff don't enter until we arrive. At that time it looked as though [the man] was in a collapsed state as I have described how he was laying across the cell. It looked basically as though he was in a coma. He didn't look as though he had a ligature around his neck, in fact the ligature was that small it was so hard to see. It was only when [the reviewing nurse] moved the body that he saw the ligature and was able to remove it. If you had known what it was, if you could see that somebody was hanging there, then obviously I would have expected somebody to, life comes before security. But in this case it looked as though he was just in an unconscious state, and that the correct procedure to follow was to wait until Oscar one or Oscar two arrived before the door was opened."

My investigators asked the night orderly officer Oscar 1 if the fact that the man was a category A prisoner would have stopped staff from going into his cell. He said:

> "I would have expected the staff on any situation whether it be a cat A or not, to respond the way that they did. The fact that he was a cat A was immaterial, the situation, the same response is required. The fact that he was a cat A makes you more aware of the risks."

74. Officer D said in her incident report that, at approximately 11.55pm, she heard the discipline officer call for urgent assistance in healthcare on the radio. She said that she attended, along with Officer E and Officer F from the top prison. Officer D noted that the night orderly officers Oscar 2 and 1 then arrived along with the case manager from the bottom prison, and the man's cell was opened. Officer D noted that at 12.12am the control room confirmed that the ambulance was on its way from the gate. She reported that during this time the accompanying nurse and reviewing nurse continued to carry out CPR on the man. She said that they were relieved by the paramedics at 12.15am.

75. In his incident report, Officer F said that at about 11.59pm an urgent message was sent for staff to attend the healthcare unit. He said that on arriving in the healthcare centre with Officer E, the discipline officer informed him that the man was slumped on the floor and that she could not get a response. He said that staff were starting to remove their night time cell keys when the night orderly officers Oscar 2 and 1 arrived and the cell door was opened.

76. Officer G said that, at approximately 11.59pm, he heard an urgent message over the radio asking for assistance in the healthcare unit. He

said that the night orderly officers Oscar 1 and Oscar 2, who were leaving F wing ahead of him, confirmed that his assistance would be required. Officer G said that, upon arrival in the healthcare centre, the man's cell door had already been opened. He said that the night orderly officer Oscar 2 was asked to get the stretcher from the ambulance. Officer G, night orderly officer Oscar 2 and another officer escorted the man to hospital, leaving the prison at 12.36am.

77. Officer E heard the call for assistance at 11.59pm. When he arrived at the man's cell, he was slumped on the floor. At this time, the night orderly officers Oscar 2 and 1 also arrived and opened the cell door.

78. My investigators also spoke with a number of prisoners who had come into contact with the man at Manchester. A prisoner on the healthcare centre, said that on the day that the man died he appeared to be happy, and had been giving out cigarettes. He was surprised that the man had taken his life. When he had spoken to the man the night before, he had seemed fine.

79. Another prisoner said that as a category A prisoner himself he had exercised with the man whilst in the healthcare centre. He said that the man was a "quiet fellow" when he first arrived in healthcare. This prisoner said that on the day that the man died they had been laughing and joking together during exercise. He said that the man did not have much money, and that he had bought things from the canteen for him. The prisoner said that, on the night of his death, the man had asked for milk and had said to him "see you tomorrow" in the usual way.

80. In her interview, the discipline officer said that the man rarely initiated conversation, keeping himself to himself. She felt that, since he had started education, he had "come out of his shell a bit". When talking of the man, during interview, the reviewing nurse said:

> "He never came across as a threat to me at all, he didn't appear that sort of guy, but he is a category A prisoner and therefore he had to be treated in a certain way."

After the death

81. Personnel from the police attended the prison and a hot debrief took place on the morning of 26 August, followed by a further debrief later that day. Members of the staff welfare team were made available to those members of staff who had found the man. All those prisoners on open ACCTs were reviewed.

82. Contact was made with the man's family in his home country as soon as practicable and a dialogue between the man's family, the prison, and the foreign embassy was opened. Due to circumstances beyond the prison's control, there was an unfortunate delay between the death of the man and the date of his funeral. The Governor made a substantial contribution

towards the funeral costs incurred by the man's family. Staff facilitated a visit to the prison by the man's family and assisted with the organisation of his funeral. Although my family liaison officer has not spoken with the man's family, I understand that they were grateful for the assistance and advice offered to them by the family liaison team at Manchester.

Clinical Review

83. In her clinical review on behalf of the Primary Care Trust, the clinical reviewer makes three recommendations. She highlights that a secondary health assessment was not undertaken and therefore the man was not physically examined when he was admitted to the healthcare centre. She recommends that all patients should have a secondary healthcare assessment, after the initial health screen, in line with agreed national policy.

The clinical reviewer draws attention to the overall high quality of record keeping, but recommends that staff be reminded of the need to ensure that all documents are signed as required. Lastly, the clinical reviewer recommends that feedback should be provided to healthcare staff on the prompt and appropriate action taken when the man's risk was identified. She said that his care was reviewed by a multi-disciplinary team and that, upon assessment of his mental state, effective intervention was provided.

Post Mortem Report

84. The Post Mortem examination reported that the man's death was as a consequence of hanging. The Head of Healthcare at Manchester believes that this was not the case and that the man died from self strangulation.

ISSUES

Delay in entering the man's cell

85. In her written statement, the discipline officer said that she discovered the man lying on the floor of his cell at approximately 11.55pm. She could not rouse him and alerted nursing staff on the unit of her concerns. The reviewing nurse and the accompanying nurse attended and also failed to obtain a response from the man. Both nurses wanted to enter the cell in order to assist the man. However, on assessing the security risk, the discipline Officer took the decision that it was too dangerous for nursing staff to enter the cell and radioed for additional assistance.

86. During the night, staff at Manchester carry radios which are on an "open net talk through" system. This means that, should an officer require emergency assistance, all staff carrying radios are able to hear the request immediately. Due to the lack of a contemporaneous control room log, my investigators have been unable to conclude with certainty the exact time at which the discipline officer made her call for assistance over the radio. However, the earliest reference to the call being made was 11.55pm by Officer D in her incident report. In their statements, three officers suggest that the alarm was raised at 11.59pm. A control room log supplied by Manchester prison, and completed retrospectively, indicates that it was midnight.

87. A number of officers responded speedily to the discipline officer's call for emergency assistance and arrived promptly from different parts of the prison. One of the first officers present, Officer E, made an instant assessment of the risk and prepared to enter the man's cell by breaking into the emergency key pouch that he carried. However, at this point the night orderly officers, Oscar 2 and 1, arrived. The night orderly officer Oscar 2 unlocked the cell door, allowing the accompanying nurse and reviewing to enter.

88. My investigators asked the reviewing nurse and accompanying nurse why they did not enter the man's cell straight away. Both said that they had wanted to enter the cell immediately but had been prevented from doing so by the discipline officer. The accompanying nurse said that the ligature around the man's neck could not be seen, and the reviewing nurse said that it was obvious that the man had collapsed and was dead.

89. The discipline officer on duty in the healthcare centre was directly responsible for security. It is right that discipline staff, given their training and experience, take responsibility for assessing the security risk to staff of any incidents that could occur. I accept that a decision had to be taken by the discipline officer on whether or not to allow nursing staff to enter the man's cell. When asked by my investigators what factors she took into account when coming to her decision, the discipline officer said she was influenced by the nature of the man's alleged offence, and the possibility

that he might have been feigning the situation in order to take a hostage.

90. Manchester's operating instructions for night patrol officers say that, upon discovery of a prisoner who has self harmed, the alarm should be raised and staff should:

> "Enter the cell in accordance with Opening Cells routines'"

They state that:

> "The key principle is that a prisoner must only be unlocked at night when it is absolutely necessary to do so."
>
> "In all cases, the permission to allow the prisoner to be unlocked must be given by the night orderly officer."

The instructions note that before unlocking any prisoner at night the control room must be informed and a minimum of a dog handler, night officer, night orderly officer and night patrol must be present.

91. Manchester's Suicide Prevention Policy, dated April 2005, clearly says at Annex 6 that, after summoning immediate emergency medical assistance, staff should:

> "Enter the cell as soon as possible. Staff may enter a single cell alone in order to preserve life (PSO 2710). Staff should wait for assistance when entering a double cell. The safety of staff dealing with the incident and the safety of the establishment is also paramount and must be taken into consideration when deciding to enter a cell."

92. The discipline officer and other members of staff seemed confused about the correct procedures for entering the cells of category A prisoners at night. In response to my draft report the Governor of Manchester prison expressed concern about the comments made about their being confusion from staff responding to the incident as to whether to enter the cell. He says that all documentation supports the evidence that the cell was entered as soon as enough staff were present, and within two minutes of the alarm being raised. He says that there is evidence that he man was extremely violent towards females and that it was a female member of staff who discovered the incident.

93. During his interview with my investigators, the night orderly officer Oscar 1, the healthcare in-patient manager, explained that nurses were permitted to enter the cells of category A prisoners as long as an officer was present. When asked about the procedures that nurses should follow when entering prisoner's cells at night in an emergency, the night orderly officer Oscar 1 said:

> "Well at night it's all about preservation of life, and if a situation arose where you need to enter the cell, then you would contact the orderly

officer, raise the alarm, let them know what's happening and then make a judgement call, whether you actually wait for staff to arrive or whether you enter the cell."

The night orderly officer Oscar 1 said that, as long as the orderly officer, had been informed, he did not have to be present in order for a nurse to enter a cell.

94. I think it would be helpful if the Governor issued clearer instructions about the circumstances in which a category A prisoner's cell can be unlocked, especially at night.

I recommend that the Governor reviews instructions regarding the entry of cells in emergency situations to ensure the proper balance between security and care.

I recommend that the Governor reminds all staff of procedures to be followed and action to be taken upon discovering a death in custody.

The man's contact with his family

95. The man's first contact with staff at Manchester was on 24 July during the reception process. My investigators were told by one officer that all prisoners were able to make a telephone call at this time, but he believed they could not make an international call. However, a senior officer said that, as the man was a category A prisoner, he would not have had the opportunity to make a call whilst in reception. Another senior officer said that he would need security clearance before any numbers he wished to call could be put on the PIN phone system. For whatever reason, my investigators have established that the man was not able to make a call to his family at this time.

96. Later that day, the man was classified as a provisional category A prisoner, and it was recorded during his reception on to E wing that he wished to contact his mother abroad. The man provided staff with the telephone number and it was noted by an officer that the senior officer on the wing was to call the number. Staff assured my investigators that attempts had been made to check the number. However, because of poor record keeping, my investigators have been unable to establish for certain whether or not this number had been called. My investigator attempted to check whether the number the man gave to staff on 24 July was correct. After approximately five minutes on the internet, my investigator was able to confirm that the number given by the man was in fact that of his mother.

97. My investigators spoke with a number of staff in order to establish what processes were in place for ensuring that category A foreign national prisoners were able to contact relatives abroad. No one appeared to know exactly what the process was. However, my investigators were able to establish that only the phone numbers of high risk category A prisoners

needed to be forwarded to the police liaison officer at the prison for clearance, the man was a standard category A prisoner.

98. Staff wrote on numerous occasions, especially in the ACCT document, that the man was having problems in contacting his family, particularly his mother. Although a number of staff tried to assist him in sorting the problem out, nobody was given sole responsibility for doing so.

99. The man's solicitor wrote to the Governor on 8 August, expressing concern that the man had not been given the opportunity to contact his mother. He received no reply. However, on the same day, a standard letter in English was sent to the man's mother with regard to her being added to a list of approved visitors. This standard letter made no mention of the man's efforts to make contact with her by phone, and did not check whether the telephone number he had given was correct.

100. It was not until the solicitor, wrote again on 15 August asking that his previous concerns be addressed immediately that he received a personal response from the prison. On 17 August, the man was given, for the first time, two air mail letters in order to make contact with his family. I do not know why it took so long for the man to be provided with airmail letters. However, on 18 August, the solicitor received a response telling him that airmail letters had been given to the man and confirming that the telephone number of the man's mother had been forwarded, for security clearance, to the police officer in charge of the case. Manchester prison point out that given the amount of legal correspondence the prison receives that to expect a reply within six days would be unreasonable. The prison says that it is for that reason they have a target to respond to correspondence within 20 working days.

101. Prison Service Order 4400 on Prisoner Communication, Prisoners' Use of Telephones, section 2.24 states that:

> "On first reception into prison from court prisoners often need to make an early telephone call to family and friends to let them know their whereabouts. *The Governor must make local arrangements to allow a call to be made within the first 24 hours of reception."*

Contrary to the Prison Service Order, the man was never given the opportunity to speak with his mother during the four weeks he was in Manchester prison to tell her where he was. He was also not provided with the means to contact his family by letter for nearly three weeks. As a consequence, the man was disadvantaged in a number of ways. Perhaps most significant, bearing in mind his mental health at the time, was the isolation from his family and in particular his mother, and the effect this may well have had upon him in the final weeks of his life. Not having contact with his family also prevented the man from receiving money to buy cigarettes and essential items from the canteen. Even by prison standards, the man had very little money to spend and as such was reliant

upon other prisoners.

102. There appears to be no written guidance at Manchester with regards to the clearance of category A prisoner's telephone numbers, and in particular those of foreign nationals. Confusion caused by poor record keeping led to a breakdown in communication between staff on E wing, the healthcare centre and security. No one in the prison knew exactly what was being done to assist the man in making contact with his family. I believe that this situation may have contributed to his feeling of isolation and despair. I conclude that the way in which the man was treated in respect of his family ties was unacceptable.

I recommend that the Governor issues guidance informing all staff of the rights of a prisoner to make a telephone call during the reception process.

I recommend that the Governor reviews the procedures for allowing foreign national, standard and high risk category A prisoners, access to telephone calls to contact family abroad within 24 hours of reception into the prison.

Emergency Bag and Defibrillator

103. The accompanying nurse and reviewing nurse responded to the discipline officer's call for assistance. The discipline officer did not allow the nurses entry to the man's cell until further assistance had arrived. Whilst awaiting the arrival of assistance, both nurses proceeded to collect emergency equipment. The reviewing nurse returned to the unit office to collect the ligature scissors. The accompanying nurse went to collect the emergency medical bag which contained resuscitation equipment and the defibrillator which was located in the downstairs area of the healthcare centre. The accompanying nurse said she arrived back at the man's cell just as it was being opened by discipline staff.

104. It is not clear why such life saving emergency equipment was held on a different level from the prisoners. However, I am pleased to learn from my investigators that an emergency bag is now located on the first floor level of the healthcare centre.

Quality of Records and Other Documentation

105. My investigation has shown that a number of records and documents completed, or accepted, by staff at Manchester, and in particular during the reception and induction process, fell well short of an ideal standard. In particular, I draw attention to the man's Page 1 (personal details) completed on Manchester's behalf by escort staff from Global Solutions Limited (GSL). Manchester prison say that there is no evidence to support the statement that records and documents fell well short of an ideal standard. They say that the officer conducting the clinical review reports the high quality of record keeping. They say that the standard of record

keeping is levelled at GSL and that the Page 1 was filled in by the external contractor.

106. The reception SO at the prison, agreed that the quality of the Page 1 completed by GSL staff had been poor. He said that reception staff at Manchester should have recognised this and rectified the omissions that had been made.

I recommend that the Governor reminds reception staff of the need to complete the 'Page 1' and other reception records accurately and to ensure that those completed by outside contractors, such as GSL, are also completed to the required standard.

I recommend that a copy of this section of my report (relating to record keeping) should be sent to GSL for their information and attention.

Spare Uniforms

107. Staff mentioned to my investigators that their uniforms became contaminated during their attempt to save the life of the man. This is not the first time that this issue has been raised. In my report into the death of a prisoner at Manchester on 5 November 2005, I made a recommendation to the Governor that replacement uniforms be made available to staff whose uniforms become soiled during the course of their work. I understand that, since making that recommendation, action was taken by the Governor. However, it is apparent from this investigation that not all staff are aware of these arrangements.

I recommend that the Governor reminds staff, and in particular night staff, of the arrangements in place should their uniforms become contaminated during the course of their work.

RECOMMENDATIONS

I recommend that the Governor reviews instructions regarding the entry of cells in emergency situations to ensure the proper balance between security and care.

I recommend that the Governor reminds all staff of procedures to be followed and action to be taken upon discovering a death in custody.

I recommend that the Governor issues guidance informing all staff of the rights of a prisoner to make a telephone call during the reception process.

I recommend that the Governor reviews the procedures for allowing foreign national, standard and high risk category A prisoners, access to telephone calls to contact family abroad within 24 hours of reception into the prison.

I recommend that the Governor reminds reception staff of the need to complete the 'Page 1' and other reception records accurately and to ensure that those completed by outside contractors, such as GSL, are also completed to the required standard.

I recommend that a copy of this section of my report (relating to record keeping) should be sent to GSL for their information and attention.

I recommend that the Governor reminds staff, and in particular night staff, of the arrangements in place should their uniforms become contaminated during the course of their work.