Investigation into the death of a man at HMP Haverigg in July 2007

Report by the Prisons and Probation Ombudsman for England and Wales

June 2008

This is a report of an investigation into the death of a man who had been at Haverigg prison for only two weeks when he took his own life in July 2007.

I would like to offer my sincere condolences to his family on their loss.

I must also apologise for the delay in issuing this report. The police began an investigation at Haverigg which needed to be concluded before we could begin ours. Therefore my investigators were unable to begin their investigation until November 2007.

The investigation was undertaken by two of my colleagues. We would like to thank the Governor of Haverigg, the Deputy Governor and their staff for their participation and assistance. A doctor was identified by the local Primary Care Trust to undertake a review of the man's clinical care. A Health & Safety Adviser, also from the Primary Care Trust, produced a review of the first aid provision at Haverigg. I would like to thank both for their helpful reviews.

Although we cannot know for certain what it was that led to the man's death, there is evidence to suggest that he may have been bullied when he moved to the D2 Billet on Fairfield Unit. The information was passed to the Security Department by other prisoners on the Unit, but sadly not until after his death. I would urge the Governor to revisit his Anti-bullying Strategy to ensure that prisoners are reassured that there is a safe environment in which they feel they can raise their concerns about bullying and that action is taken by staff. I was also concerned that the first officers to discover him were not carrying anti-ligature knives, despite the requirements of a Prison Service Order which makes this mandatory for all staff who have contact with prisoners. I realise this would not have made a difference to the man, as he had already died by the time the officers arrived. I am pleased that the Governor has now issued anti-ligature knives to all staff who are required to carry them.

I make two recommendations to the Governor.

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

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SUMMARY

The man was discovered in his cell at HMP Haverigg on the morning of 5 July 2007, with a ligature made from a bedsheet tied around his neck. Despite the efforts of staff, he could not be revived. He had been in Haverigg just two weeks when he died.

He began his sentence for this offence at HMP Preston, but he soon applied for a move to HMP Haverigg and transferred there on 20 June 2007.

During his brief time at Haverigg, the man rarely came to the attention of staff and seemed to be a quiet and private person. He spent just over a week on the First Night Centre before he moved onto D2 Billet of Fairfield Unit, just four days before he died.

Once on the D2 Billet, the man shared a cell with another prisoner who, it seems from security information, became involved in an incident with a group of other prisoners. It appears that as the man was his cell mate he became implicated in this feud also and may have been bullied as a result. Again, this is implied in security information forwarded to staff by prisoners, after he had died. It is impossible to know for certain whether this had an impact on his decision to take his life.

The man raised no concerns during his induction about his state of mind or the likelihood of harming himself and so was not considered for monitoring on an ACCT. He did agree to a referral to the prison's CARATS team with the intention of continuing to address his drug addiction which he had begun at Preston. However, at the post-mortem there were traces of opiates in his urine specimen, which indicated he had used morphine or heroin a few days before he died.

Staff spent over 20 minutes trying to resuscitate the man before the paramedics arrived, but sadly the prison doctor pronounced him dead at 12.15pm.

THE INVESTIGATION PROCESS

1. I appointed two of my colleagues to conduct the investigation on my behalf. Another investigator from my office made an initial visit to Haverigg on 9 July 2007, to visit the cell where the man died and to meet with staff at the prison. The initial investigator also collected documents, including the medical record, for use in this investigation. Notices were issued to both prisoners and staff inviting anyone who had information relating to the man's death to make themselves known to the investigator. However, no additional witnesses came forward.

2. Almost immediately, this investigation was suspended in light of a criminal investigation which began, and took precedence, over this one. My investigators could only resume their investigation on 18 October 2007, once the police enquiries had been completed. This contributed to the delay in producing my report.

3. My colleagues returned to Haverigg to carry out taped interviews with staff on 14, 15 and 16 November 2007. They also visited the cell where the man died. Given the amount of time that had elapsed from the day he died to when my investigators were permitted to begin their investigation, some witnesses had remembered events slightly differently. However, my investigators believe they were still able to form a clear picture of what had happened on the day the man died by speaking to those people who were directly involved in discovering and attempting to resuscitate him.

4. One of my Family Liaison Officers (FLO) contacted the man's next of kin (his mother) to explain the role of the Prisons and Probation Ombudsman and to offer her the opportunity to participate in the investigation process. His mother said she had some questions she would like the investigators to consider. Firstly, she understood that whilst he was at Preston prison, her son underwent a methadone programme and wondered what had happened about his detoxification once he transferred to Haverigg. She also wondered whether there was continuity of care between the two prisons. The man's mother asked whether her son had taken any drugs whilst he had been at Haverigg and told the FLO that she had received a letter from him two days before he died, in which he had asked for some things to be sent in to him and had mentioned seeing his sons and had generally seemed settled. This suggested to his mother that he expected to be at Haverigg for a while.

5. A clinical review of the man's health care whilst he was in custody at Haverigg was undertaken by a doctor on behalf of the local Primary Care Trust (PCT). A review of Haverigg's first aid provision was reviewed by a Health and Safety Advisor for a second PCT.

HMP HAVERIGG

6. Haverigg is a category C prison, situated in the small town of Millom in Cumbria. The prison opened in 1967 and occupies an old RAF airfield. At the time of the man's death Haverigg held 558 prisoners.

7. Haverigg's accommodation is divided into four residential wings. Residential Unit one is a purpose built cellular house block with two wings (A and B) each housing 60 prisoners in single cells. Residential Unit Two comprises nine cellular billets with both single and double rooms and can accommodate 196 prisoners. Residential Unit Three includes seven billets with mainly single rooms for 126 prisoners. Residential Unit Four comprises 40 rooms in a ready to use unit.

Anti-bullying Strategy

8. Haverigg's Anti-bullying Strategy policy document was issued on 1 October 2004. Its aim is to create a safe environment where prisoners and staff work together to reduce bullying. It also aims to foster an environment in which anyone who is aware of bullying feels safe and able to alert staff to the problem.

Anti-ligature knives

9. Anti-ligature knives, also known as 'fish-knives' or 'cut down tools' are implements designed to cut ligatures. All staff in closed and semi open prisons, who have contact with prisoners, must be provided with and carry on duty their own personal issue knife.

Prison Service Order (PSO)

10. PSOs are mandatory instructions for prisons to implement. PSO 2700 refers to the issue of anti-ligature knives. The main action of the PSO is that all unified and uniformed staff in closed and semi-open prisons must be provided with and carry their own personal anti-ligature knife.

Assessment, Care in Custody and Teamwork (ACCT)

11. ACCT requires any member of staff who identifies concerns about a prisoner at risk of suicide or self harm to take action and to record those actions. The ACCT document should be available to all staff where the prisoner is located, including workshops and visits. Within 24 hours of an ACCT being opened, the prisoner is seen by an assessor and has a case meeting review. ACCT reviews are held at appropriate intervals and are attended by the prisoner and a case manager, together with other members of staff.

Counselling, Assessment, Referral, Advice and Throughcare Service (CARATS)

12. Organisations specialising in the treatment of substance abuse have drugs workers based in most prisons. CARATS workers run programmes, offer counselling, support and referral to rehabilitation centres to prisoners and on release. Access to CARATS is voluntary and prisoners must agree to a referral.

Code Blue

13. In the event of urgent medical assistance being required, the prison has a radio code system to alert staff to the emergency situation. A Code Blue alerts staff that the prisoner is having difficulty breathing or has stopped breathing. This system ensures that medical staff take the correct emergency equipment with them, when responding to the call.

First Night Policy

14. Haverigg's First Night Policy was last reviewed in January 2006. The policy document is intended to be used as an aid to staff on the First Night Reception when they are interviewing a new prisoner and is completed in conjunction with a cell sharing risk assessment. The purpose of the first night interview is to ensure that any potential problems a prisoner might have will be identified and dealt with at an early stage.

Healthcare

15. The Primary Care Trust provides health care to Haverigg. It runs a service from 8.00am to 5.00pm and an out of hours GP service.

Listeners

16. The prison has a Listener scheme which is a system where the Samaritans train selected prisoners to be the first contact for any prisoner who is feeling vulnerable and at risk. The scheme is confidential and any prisoner can request to speak to a Listener at any time.

Suicide Prevention Policy

17. The Suicide Prevention Policy was last reviewed at Haverigg in September 2006. It refers to the Samaritans service, use of prison Listeners, the ACCT process and instructions and advice for staff involved in dealing with prisoners who harm themselves and contacting their next of kin.

Previous deaths in custody

18. There have been two other deaths at Haverigg since 2004. One prisoner died from natural causes in 2004 and another took his own life in October 2007.

Her Majesty's Chief Inspector of Prisons (HMCIP) report

19. Haverigg was inspected in an unannounced visit follow up inspection by HM Inspector of Prisons in August 2006. The report noted that since their previous inspection in 2003, Haverigg had continued to improve arrangements to ensure prison safety. First night officers, supported by Listeners, now saw all new prisoners and anti-bullying procedures had been revised. However, it was disturbing that while instances of self harm were low, suicide prevention procedures were poor and under resourced. Poor perimeter security, a sprawling site and limited staffing meant that drugs, alcohol and mobile phones remained a challenge for staff. The report concluded by saying that overall, staff and managers at Haverigg deserve congratulations on the progress they have made, particularly given the challenges of the prison's location and the inadequacies of the site.

Independent Monitoring Board (IMB) report

20. The latest IMB report was published in July 2007 and covered the period December 2005 until November 2006. It expressed concern about the constant problem of drugs, brewed alcohol and mobile phones in the prison, although it reported that the vigilance of staff, routine and random searches and up-graded cameras on the perimeter fence had kept the problem under control. The report also mentioned the problem of bullying at Haverigg and that they have an anti-bullying policy. The IMB also noted that staff-prisoner relationships were generally positive and that officers treat prisoners with professionalism and respect which is generally reciprocated.

KEY FINDINGS

First reception

21. Upon reception at Haverigg, the man was seen by a member of staff (who did not sign the First Night Policy document and cannot be identified) with the intention of assessing his risk of self harm, history of drug use and any other concerns. At this meeting the man stated that he had no concerns about transferring to Haverigg, had never committed an act of self harm and did not feel at risk of self harm. He also said he had used cannabis, cocaine, heroin, solvents and methadone, but was not suffering from any withdrawal symptoms. He agreed that he would benefit by a referral to the CARATS team.

22. A cell sharing risk assessment was also completed the same day and the man was assessed as a low risk and was therefore able to occupy a shared cell. He was also seen by a prison nurse for a Transfer Health Screen which is completed when a prisoner is moved to a new prison. The prison nurse noted that the man had a leg wound, which he had had for a while and for which he had been prescribed antibiotics whilst at Preston prison. The man told the prison nurse that he had been referred to hospital in 2006 for mental health problems and had thought of harming himself and taking his own life at the time. However, he said he had no such thoughts at present and was therefore not referred to the Mental Health Team and neither was an ACCT raised. He was initially located in Skiddaw Unit, the first night centre and moved to Fairfield Unit, D2 Billet, just over a week later.

23. Only three entries were made on his wing history sheet. On 22 June, an entry was made stating that the man had been advised of rules and regulations. On 29 June, an entry says that he was a quiet lad who has not come to the attention of staff. The final entry on 1July, indicates that he was moved on to the D2 Billet.

CARATS intervention

24. The man had regular contact with the CARATS team whilst at Preston and was assessed by a member of their team on 20 June, just before he was transferred to Haverigg. The Transfer Plan summarised the main issues and key achievements for him, which he agreed to continue working towards at Haverigg. The CARATS worker wrote that the man was interested in undertaking the Prisoners Addressing Substance Related Offences (PASRO) course, but not at that time. (This document was received at Haverigg on 27 June 2007.) He attended a CARATS induction on 22 June 2007, and it was jointly decided between him and the worker that he would like contact with the Haverigg CARATS service and would therefore be allocated a worker, although this did not appear to have happened before he died.

Healthcare involvement

25. There were only two entries made in the man's Inmate Medical Record (IMR) once he had transferred to Haverigg. The first of these was made on 21 June when he was seen by the prison doctor who noted the infected lump on the man's thigh and also the drugs that he was currently taking for this. The second and last entry was made on 5 July, when the prison doctor certified that the man had died.

Information regarding bullying

26. It appears from Security Information Reports (SIRs) that the man's cell mate, had become involved in an incident with a number of other prisoners, which resulted in him being moved onto a different unit. However, it does appear from the information given to my investigators that the man may have become involved, simply because he had shared the cell with him. SIRs submitted on 5, 6 and 13 July by other prisoners suggest that the man had been bullied as he had, in effect, taken on his cell mate's debt. This information was forwarded to senior staff, but it is unclear from the documentation what action, if any, was taken.

Events of 5 July

27. On Fairfeld Unit, D2 Billet, prisoners are generally unlocked at 8.00am and those who have jobs are sent to work. Most prisoners are allocated jobs at Haverigg as it is a working jail. The man had not yet been allocated a job as he had been assessed as a high risk on the Security Risk Assessment for Work review on 4 July 2007. Prisoners who are not working or attending education classes or courses are locked in their cells, after collecting their breakfast packs, until approximately 11.00am. He therefore remained in his cell on the morning of 5 July, until it was time for him to be unlocked again.

28. At approximately 11.00am, an officer opened the gate to Fairfield Unit to allow prisoners who had attended the PASRO course back into the Unit. Immediately afterwards, the officer decided to unlock the remaining prisoners on D2 Billet and the first cell she came to was the man's.

29. The officer pulled back the flap to observe the cell through the observation panel but it was covered, obscuring her view. She said at interview that this was not unusual, as prisoners would often cover their observation panel. She continued to unlock the door and then push it open. As the officer pulled back the flap she immediately saw the man hanging from the toilet cubicle. It appeared that he had used a broom handle placed across the partition either side of the toilet door and attached a ligature, made from a bed sheet. In disbelief, the officer quickly pulled the door shut and locked it, but immediately opened it again, as she could not believe what she had seen and thought it might have been a practical joke. The officer looked again at the man. She thought that he showed no signs of life and also realised she was not carrying an anti-ligature knife, so she closed the door again.

30. The officer realised she needed a more senior officer to assist her, so she put a call out over the radio for Oscar Three (which was held by a Senior Officer) to attend D2 Billet immediately. As the radio was not on talk-through the officer did not hear the response from Oscar Three, but could tell by the way the Communications Department acknowledged her call that he was on his way to Fairfield Unit. The officer then put another call through for any staff on Fairfield Unit to attend the D2 Billet.

31. While she was waiting for a response, the officer noticed a colleague at the end of the Billet, letting some prisoners into the D9 Billet, also on Fairfield Unit. The officer shouted out to her colleague, who said at interview he could tell it was urgent as she had called him by his first name. Her colleague rushed to D2 Billet as soon as he had let the prisoners through and the officer beckoned him to the man's cell. The officer said to her colleague "somebody's hanging" whilst unlocking the man's cell and they both entered it. The colleague asked the officer if she had raised an emergency call and as she had not, he instructed her to put out a Code Blue call sign, which is the emergency code for a person who appears not to be breathing.

32. Neither officer was carrying an anti-ligature knife and so they decided to support the man's body until somebody else attended and they were able to release the ligature. The colleague remembered that the man had appeared very grey in colour and the officer recalled that he felt quite stiff to the touch. Oscar Three quickly arrived at the man's cell and whilst the officers continued to support the man's body, he used his anti-ligature knife to cut the ligature.

33. All three officers lowered the man to the floor and Oscar Three checked for signs of life. The man did not appear to be breathing, his pulse could not be detected and Oscar Three recalled he felt very cold to the touch. He also believed that rigor mortis had begun to set in as the man's arms had felt stiff to him.

34. Whilst Oscar Three was still checking for the man's vital signs, a third officer and the prison nurse, who had both responded to the Code Blue emergency call, arrived at the cell, within approximately three minutes. The prison nurse brought the orange emergency 'grab bag'. At that point Oscar Three and the first two officers on scene all left the cell. The prison nurse noted that the man appeared very cold and although he did not appear cyanosed there was no response from him at all. (However, at interview the third officer recalled that he was slightly cyanosed.)

35. The prison nurse and third officer commenced cardio pulmonary resuscitation (CPR). The prison nurse gave two breaths to every 15 chest compressions that the third officer administered. The prison nurse managed to open the man's airway, although he had some difficulty doing so. When he gave mouth to mouth to the man, the third officer could see that his chest was lifting. The prison nurse and third officer continued to carry out CPR for approximately 20 minutes. Another member of healthcare staff brought a defibrillator and also tried to relieve the prison nurse by attempting to carry out mouth to mouth

resuscitation, however as she was unable to get the breaths into the man, the prison nurse resumed this.

36. The paramedics arrived approximately 25 minutes after the man was discovered. The third officer and prison nurse continued to administer CPR while the paramedics set up their equipment and attempted to open the man's airway again, as it had collapsed. They continued to work on him for approximately five minutes. However, they were unable to resuscitate him and the prison doctor attended the cell at 12.15pm to confirm that the man had died.

37. The man's mother received the news of his death from local police, as she lives in Scotland and the prison were anxious that there was no delay in contacting her. The Governor and prison chaplain subsequently contacted his mother.

38. His funeral was held on 19 July. The prison paid for the funeral which was attended by representatives of the prison and flowers were sent on behalf of both staff and prisoners.

Post mortem

39. The man's post-mortem was held on 6 July, at the hospital mortuary. Preliminary screening tests were carried out on a blood specimen and a urine specimen for a range of drugs including benzodiapines, methadone and opiates (for example heroin, morphine, codeine and dihydrocodiene). These screening tests were negative on the blood specimen, but gave positive indications for the possible presence of opiates in the urine specimen. This indicated that the man had not used morphine or heroin in the hours leading up to his death, but may have used it a few days before. The cause of death was recorded as hanging.

Aftercare for prisoners

40. The Samaritans were informed about the man's death, in case they received calls from prisoners. Listeners were also briefed to enable then to support any prisoners who felt distressed. All prisoners who were on an ACCT at the time the man died were reviewed, but staff had no concerns. The Chaplains continued to provide on-going support for those prisoners who needed it.

Aftercare for staff

41. Members of the Care Team attended the wing office in Fairfield Unit very quickly and spoke to all of the staff who had been involved in the discovery and attempted resuscitation of the man, in particular the first officer on scene. Other senior staff also checked on her and her colleague. The Care Team kept in regular contact with the officer during a period of sick leave, as did Oscar Three. When the officer returned to work in August 2007, it was on a phased return, beginning with administrative duties for approximately one month.

42. A hot de-brief was held later that day and a critical incident de-brief for staff was held about three weeks after the man died. The colleague found this helpful, although the first officer on scene felt that it had taken place too soon after the man's death and she still felt very emotional. The prison nurse did not recall being invited to attend either of the de-briefs and thought that it would have been helpful.

ISSUES

Clinical issues

43. An independent clinical review into the man's care whilst he was at Preston and Haverigg was commissioned. The clinical reviewer found that during the man's health screening at Preston it was recorded that he had no thoughts of suicide or self harm and was referred to the prison's medical officer because of his substance misuse, where he commenced a 12 day detox programme on 14 April 2007.

44. The clinical reviewer also notes that the man's transfer to Haverigg was satisfactory. During his health assessment by the prison nurse there is reference to the man's referral to mental health services in 2006, but that nothing was troubling him when he arrived at Haverigg and he did not need a further referral. In particular it is recorded that an ACCT document was not needed. The clinical reviewer said that given the limitations of any screening tool or procedure, there was no evidence that the man was at increased risk of self harm and no reason why he would have been placed on any special surveillance (an ACCT). The clinical reviewer concludes that the procedures to assess whether the man was at risk of self harm were satisfactory and did not indicate that this was the case.

Anti-ligature knives

45. At the time of the man's death, staff did not routinely carry anti-ligature knives. The Governor's attention was drawn to Prison Service Order 2700 (which states that all staff who have contact with prisoners must carry an anti-ligature knife) and I understand that Haverigg have now implemented it. However, I concur with the clinical reviewer that carrying knives would not have made a difference to the man, as by the description of the officers who attempted to resuscitate him, he had already died by the time he was discovered.

    The Governor should confirm that the roll out of anti ligature knives has been completed and that all staff have now been issued with this equipment.

Bullying

46. After the man's death a number of prisoners submitted SIRs which indicated that he had been bullied by other prisoners. Although this information came to light after he had died, my investigators believe that a culture of bullying exists at Haverigg, in particular between rival, geographically based, gangs. His cell mate was moved the day before the man died, due to an incident between himself and members of a gang, seemingly from Liverpool. It appears that the man became involved in this simply by virtue of who he shared a cell with. Staff should be extra vigilant in identifying instances of bullying and potential victims, especially when information is given via an SIR, and should also revisit their anti –bullying strategy policy document.

The Governor should revisit their prisons anti-bullying strategy and be aware of how to identify and deal with instances of bullying amongst prisoners. When bullying is discovered, action should be taken by staff.

Family's concerns

47. In response to the questions raised by the man's mother, my investigators can confirm that her son completed a 12 day detoxification programme at Preston prison. He attended a CARATS induction two days after he arrived at Haverigg and, despite initially declining a referral, subsequently agreed to be assigned a CARATS worker.

48. The man's mother asked whether her son had taken drugs whilst at Haverigg. The post mortem report indicated that he may have used morphine or heroin a few days before he died. My investigators discussed this with the Deputy Governor, who is aware of the problem of drugs at Haverigg (and also at national level).

RECOMMENDATIONS

To the Governor

1. The Governor should confirm that the roll out of anti ligature knives has been completed and that all staff have now been issued with this equipment.

2. The Governor should revisit their prisons anti-bullying strategy and be aware of how to identify and deal with instances of bullying amongst prisoners. When bullying is discovered, action should be taken by staff.