Investigation into the circumstances surrounding the death of a man at HMP Forest Bank in July 2007

Report by the Prisons and Probation Ombudsman for England and Wales

October 2008

This is the report of an investigation into the death of a man who was found hanging in his cell at HMP Forest Bank on 15 July 2007. He was 38 years of age.

I would like to offer my own and my colleagues' condolences to the man's family and friends. I hope that my report addresses all the concerns they may have. I must also offer my apologies for the delay in its completion.

The investigation into the man's death was carried out on my behalf by one of my investigators. A clinical review was conducted by Salford Primary Care Trust (PCT). I would like to thank the then Director of Forest Bank and his staff for their co-operation and assistance.

The man had been in Forest Bank for a number of months and was an enhanced prisoner with no warnings or adjudications against him. However, two weeks after his arrival at the prison, the man had referred himself to the mental health team. He was assessed and diagnosed as suffering from depression. Although the man's mental health appeared to improve, on the afternoon of 14 July 2007 he received a telephone call from his partner ending their relationship. Some time the following evening, the man appears to have taken his own life.

This is the first apparently self inflicted death to have occurred at HMP Forest Bank since my office began investigating all deaths in prison custody in April 2004. My investigation into the man's death highlights a number of lessons regarding healthcare issues and the staff response when an alarm is raised.

I have made nine recommendations and indicated a number of other issues that the Director of Forest Bank will wish to address.

Stephen Shaw
Prisons and Probation Ombudsman **October 2008**

CONTENTS

Summary	4
The investigation process	6
HMP Forest Bank	9
Key findings	10
Issues	18
Recommendations	23
Annexes	24

SUMMARY

The man was transferred to Forest Bank from Ashton-Under-Lyne Police Station on 30 March 2007. The man's escort records said that he suffered from mental health problems. On his arrival at Forest Bank, the man went through the standard induction process. Although part of the reception process involves a medical assessment, my investigation has found no evidence to confirm that the man received one.

The man settled into prison life quickly and his records indicate that he had no known problems. However, on 11 April 2007, the man approached a member of the Mental Health In Reach Team (MHIRT) asking to be seen by someone. A mental health assessment was conducted on 24 April. It was recorded in his medical record that he was feeling low and depressed and was experiencing suicidal thoughts. The man was prescribed anti-depressants.

After the man's assessment, two members of the mental health team discussed whether it would be necessary for him to be put on an Assessment, Care in Custody and Teamwork (ACCT) document. (The ACCT is a document used to assess, observe and support prisoners at risk of self harm.) A decision was taken that, at that stage, the man would not be placed on an ACCT but would be assessed for any increased risk of suicide.

Over the subsequent weeks, the man was assessed weekly by members of the MHIRT. Although no significant change in his mood was noted, the man told staff that he continued to feel low. He felt his medication was not working and he was sleeping poorly. MHIRT staff told the man that his medication would take time to work and that it would be reviewed in a couple of weeks.

On 24 May, the man was again seen by a member of the MHIRT. Once more he reported symptoms of depression and disturbed sleep, but denied any thoughts of self harm. The strength of the man's medication was increased.

Entries on the man's wing history sheets recorded that he was pleasant, polite and quiet, and caused no problems on the wing. As a consequence of his good behaviour, the man was given enhanced prisoner status on 1 July. An officer who regularly had contact with the man said that he had a nice manner and never seemed to complain about much.

The man was seen again by a member of the MHIRT on 6 July. It was reported that, since the increase in dose of his medication, his mood had lifted significantly and there had been an improvement in his energy and motivation levels. In the weeks leading to his death, the man showed no signs of depression and was optimistic about his future.

At around lunchtime on 13 July, the man and his sister discussed the possibility of his son being brought into prison to see him. Soon after, the man spoke to his partner who informed him that she would not allow the visit. The man spoke with his sister again that evening, discussing possible alternative arrangements for his son to visit.

On 14 July 2007 at 12.46pm, the man had a difficult telephone conversation with his partner. She informed him that she would not allow him to see their son and told the man that she no longer wished to see him, ending their relationship. On finishing the call, the man was seen to smash the telephone receiver.

The man was heard to slam his cell door on two separate occasions that afternoon. On investigating, staff found the man sitting on his bed, upset and angry. A prisoner who was sitting with the man said that he had received a bad phone call. Before lock up that evening, the man apologised to staff for his behaviour earlier in the afternoon.

At 3.28am the next morning (15 July 2007), the man was found hanging from the door of his cell. On being alerted to the emergency, staff went to the man's cell. It was clear that the man had been dead for some time so cardio pulmonary resuscitation was not attempted. The man was subsequently pronounced dead by paramedics at 4.15am.

As a result of my investigation, I have made nine recommendations to the Director of Forest Bank. In particular, I have asked him to review the prison's night procedures and advice to staff on when to enter a cell when a prisoner has apparently self harmed. I have also asked him to consider changing the emergency call signs used at Forest Bank in order to make them easier for staff to understand.

I have made a number of recommendations relating to healthcare issues in the prison. These include a recommendation that the Director ensures that all prisoners entering Forest Bank receive the mandatory healthcare assessment. I have also recommended a local review of issues surrounding self harm risk and medical confidentiality. I have also been concerned that staff may not be recording their interactions with prisoners as effectively as they could, and that there is uncertainty as to the actions to be taken at night if a prisoner is found in a medical emergency,

THE INVESTIGATION PROCESS

1. My investigator carried out the investigation into the man's death. Notices were issued to staff and prisoners at HMP Forest Bank informing them of the investigation and inviting them to contact my investigator. My investigator met the Director of Forest Bank and the chair of the Independent Monitoring Board (IMB). He also made himself known to the local union representative.

2. My investigator was shown the wing on which the man spent the last months of his life. 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. An independent clinical review was undertaken on behalf of Salford PCT. My investigator spoke with a Detective Inspector (DI) from Greater Manchester Police who is acting on behalf of the Coroner. 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 with her enquiries.

4. The investigators had access to a copy of the CCTV footage from D wing. Having reviewed the footage they established that the recorded timings are approximately five minutes behind actual time. For the sake of clarity, the CCTV timings quoted in this report have had an additional five minutes added so that all timings correspond.

5. One of my family liaison officers, spoke with the man's mother. The man's mother raised a number of issues. She said that the man was generally a 'happy-go-lucky' person and that his family were in shock with what had happened. However, she recognised that something was wrong when the man was in prison because of his weight loss and depression. She believed that this was because the man's girlfriend would not allow him to see his son in prison and had refused to compromise.

6. The man's mother told my family liaison officer of her concern that the man might have obtained sleeping pills from another prisoner and that these may not have mixed well with his anti-depressants. Although my investigator was unable to establish whether or not this was the case, I understand that there would have been no contra-indication to prescribing sleeping tablets with anti-depressants.

7. The man's mother explained that the police had broken the news of the man's death to her shortly before she and members of the family were due to visit him in prison. She said that, although the police were kind, they were unable to give her any specific information as to what had happened.

8. The man's mother talked positively about the help and support she and her family had received from the prison. She said that the funeral expenses had been met. The family visited Forest Bank and spent some

time in the man's cell. The man's mother confirmed that all of the man's belongings were returned to her, and she commented on the sensitive way in which this had been done. The man's mother said she was very grateful for the efforts made by staff at Forest Bank.

HMP FOREST BANK

9. Forest Bank is a local prison in Greater Manchester and is managed and operated by Kalyx, a private company. Built on the site of a former power station, the prison opened in 2002. It has a population of over 1,000 remand, convicted and sentenced adult male prisoners and young offenders. The prison serves all courts in the Greater Manchester area.

10. The establishment consists of six house blocks. Each block contains two wings and there are two landings on each wing. D wing is an enhanced wing with a capacity of approximately 175 prisoners.

11. Healthcare facilities at Forest Bank are provided by Kalyx. GP, pharmacy and dentistry services are contracted out and are provided by local practitioners. Services provided by the Mental Health In Reach Team are commissioned from, and delivered by the Salford Primary Care Trust.

12. In August 2005, Forest Bank underwent an unannounced short follow up inspection to that completed in 2002 by Her Majesty's Chief Inspector of Prisons, Ms Anne Owers. In 2002, Ms Owers had described Forest Bank as a very good local prison. However, in 2005 she noted her disappointment that progress had not been maintained, highlighting a significant deterioration in safety.

13. The man had no contact with the prison's Independent Monitoring Board during his time at Forest Bank.

KEY FINDINGS

14. The man was received into custody at Forest Bank on 30 March 2007. During his time at Forest Bank, the man appeared at court on a number of occasions (the last being on 28 June). At the time of his death the man was awaiting sentence.

15. Global Solutions Limited (GSL, now part of the company G4S) provide escort services on behalf of Forest Bank. GSL staff noted in a Court Application Form (used when the man transferred from Ashton-under-Lyne police station to Forest Bank on 30 March 2007) that the man had a 'mental condition'. This information appears to have been obtained from a Prisoner Escort Record dated 29 March in which it said the man suffered from mental health issues and had been treated for burns. (No other escort forms make reference to the man's mental health. It is not clear how the man received his burns, although he had been remanded into prison for arson.)

16. Upon his arrival at Forest Bank, the man was given a guided tour of his wing, D2, and had an induction interview at which he was provided with general information about prison life. The man gave his partner's name and contact details as his next of kin.

17. The man acknowledged on a Reception/Induction Checklist that a medical examination would form part of the reception process. (My investigator has found no evidence to suggest that an examination or first reception health screen actually took place.) A cell sharing risk assessment was completed by the reception officer concluding that the man would not be a risk to other prisoners.

18. An entry on 8 April 2007 in the man's wing history sheet said that he had settled onto the wing and had no known problems. On 22 April, it was recorded by wing staff that he had 'no issues'. It was recorded in the man's medical record that on four occasions during early April he was seen by healthcare staff to renew dressings for his burns.

19. On 11 April, the man approached a member of the Mental Health In Reach Team (MHIRT) at the prison. He appeared distressed and asked if he could be seen by a member of the team. (Members of the Mental Health In Reach Team at Forest Bank are employed by Salford Primary Care Trust (PCT). The team runs a system of open referrals. Prisoners are able to make referrals themselves or can be referred by medical officers or any other member of staff. The aim of the team is to see all non-urgent referrals within 14 days and urgent referrals the same day.)

20. The man was seen by a mental health assessor on 24 April, fourteen days after having referred himself. The assessor was on placement with the MHIRT at Forest Bank. She later discussed her assessment with her supervisor a Registered Mental Health Nurse (RMN) and Assessment, Care in Custody and Teamwork (ACCT) trainer. (The ACCT is a

document used to assess, observe and support prisoners at risk of self harm. It highlights the problems and possible trigger points of a prisoner at risk of self harm, and delivers a multi-disciplinary plan to give prisoners support and help through a period of crisis.) The registered mental health nurse recorded in the man's medical record that he had:

> "… been feeling low and depressed for the past year currently experiencing suicidal thoughts, in the evening. Has thought about hanging himself, no immediate plans to act on thoughts. Discussed presentation with G.P. prescribed Citalopram 10mg OD. Will review twice a week, and assess mental state/current risk."

The mental health assessor also noted the man's history of suicide and that he had made an attempt to hang himself in 1988. She recorded that, should his risk of self harm increase, he should be placed on an ACCT book.

21. My investigator asked the registered mental health nurse whether she had considered opening an ACCT document when she became aware of the man's thoughts of suicide. The registered mental health nurse said that she had discussed it at length with both the mental health assessor and the man and the decision was taken that it would not be necessary. The registered mental health nurse went on to say, "… our plan was to continually assess the risk of suicide and if we felt it was to increase, then we would place him on an ACCT document."

22. The registered mental health nurse saw the man for a second time on 27 April. She wrote in his medical record that there was no improvement in the man's mental state, and that he had not been sleeping well due to problems with his partner and not being able to see his son. The registered mental health nurse explained to the man that it might be a couple of weeks before he felt the effect of his medication.

23. On 3 May, the registered mental health nurse visited the man on the wing. She noted no significant change in his mood. The man felt his anti-depressant medication was having no effect. He denied any thoughts of suicide but his lack of sleep continued to be a major problem. The registered mental health nurse again told the man that his medication would take a number of weeks to work.

24. In an entry on the man's wing sheets dated 6 May 2007, an officer records that the man was polite, compliant and had no known problems. On 10 May, The registered mental health nurse saw the man again. She said that there was no improvement in his mental state and that he continued to feel low and was not sleeping. The man said that his medication continued to have no effect. The registered mental health nurse replied that his medication would be reviewed in a couple of weeks.

25. The man's wing history sheets say that on 20 May he continued to be "polite and compliant". During a review by the registered mental health

nurse on 24 May, the man reported symptoms of depression and disturbed sleep. However, he denied any current thoughts of suicide or self harm. The registered mental health nurse liaised with the prison GP and organised an increase in strength of his anti-depressant (Citalopram) to 20mg, with a review in two weeks time.

26. On 26 May, wing history sheets record the man as being “pleasant and polite, no change.” An entry on 30 May recommending that the man be given enhanced prisoner status said, “The man is quiet and compliant, causes no known problems on HB D2 – has had no warnings or adjudications since arrival – recommend enhanced status.” The man was given enhanced prisoner status on 1 July.

27. The man was seen again by the registered mental health nurse on 6 July. She wrote in his medical record, that since the increase in dose of his anti-depressants, the man had reported that his mood had lifted significantly, with an improvement in his energy and motivation levels. She said he continued to deny any thoughts of self harm. However, she noted that the man continued to suffer from poor sleep, saying that he often only got three hours sleep a night and woke early in the morning. The registered mental health nurse told my investigators that in the weeks leading to the man’s death there was, “… no evidence of depression, he was bright, he’d put weight on, he was going to the gym and he was reasonably optimistic about his future.”

28. Prisoner Custody Officer (PCO) an officer who regularly worked on D wing, said that the man:

    > “… had a nice manner, and never seemed to complain about much, if he had a problem he would come and see you, he wouldn’t come ranting and raving at you, he was quite respectful.”

    In the weeks leading to the man’s death, the custody officer said that his behaviour was consistent with his normal mood. Another officer who also worked on D wing, said that he did not know the man well but confirmed that he was quiet and compliant.

29. At 12.39pm on 13 July, the man had a telephone conversation with his sister. They discussed the man’s mother visiting him in prison and bringing his youngest son. The man asked his sister to contact his partner in order to make arrangements for his son’s visit. Soon afterwards at 12.46pm, the man spoke with his partner. During their telephone conversation she told him she would not allow their son to visit in prison.

30. That evening at 6.04pm, the man spoke with his sister once again. They discussed possible travel arrangements for his son to visit him in prison.

31. The man spoke with his partner on Saturday 14 July at 12.46pm. During their conversation she ended their relationship. She told the man that she no longer wished to see him and that she would not allow him to see his

son. A prisoner knew the man and occupied cell 58, the cell next door (The man was in cell 59). The prisoner told my investigators that he was using the telephone next to the man at the time. He said that the man repeatedly smashed the telephone receiver after speaking to his girlfriend.

32. Another prisoner, with whom the man had socialised, occupied the other cell adjacent to the man (cell 60). The prisoner told police that around 2.00pm on 14 July he heard the man slam his cell door five or six times. The prisoner said that he went to have a look and, on seeing the man's cell door closed, decided to leave him alone. At about 2.30pm the man came out of his cell and stood on the landing, where he was joined by the prisoner. The man informed the prisoner that his girlfriend had just told him she was going out with another man that evening and this had "done his head in". The prisoner attempted to comfort the man as he looked depressed and seemed upset.

33. At about 2.00pm the two custody officer's were on D wing when they heard a cell door slam on the first landing. The custody officer said that on looking up he saw the man's cell door swing back open, with the man sitting in his cell. The officer went to investigate. He said the man was:

    "… sat in his cell with his mate from next door, and I could see he was visibly upset and I said you know, 'What's going on like, what's the matter' and the prisoner from next door said, 'Oh he's alright boss, he's had a bad phone call, I'll sort it out, he will be okay.' So with that I said 'Alright then fine' and I came away …"

34. The door to the man's cell was again banged several times at around 3.00pm. The custody officer went upstairs to see what was wrong. The custody officer told my investigators that the man was lying on his bed and was obviously upset, angry and shaking. The prisoner from the cell next door was sitting in the cell with the man. The prisoner told the officer that the man had received a bad phone call. The custody officer decided to give the man a "bit of space" because he had just received a bad phone call.

35. The PCO said that, at about 3.30pm, the man came down to the wing office and asked if he could speak to a member of staff from the chaplaincy. The PCO said that he made the call and, as the man had requested, left a message for a member of the chaplaincy to visit at their earliest convenience. The PCO said that he could see that the man was upset and again asked him if he wished to talk about anything. The man did not want to.

36. During the afternoon the man asked the other prisoner to cut his hair. However, he was unable to do so as no one was prepared to lend him some hair clippers. The prisoner said that shortly before lock up at 5.00pm he told the man that he would see him in the morning, to which the man had replied "yeah". The prisoner did not speak with the man after

lock up, but the man gave no indication of his intention to harm himself. The prisoner from the cell next door said that the man was "up and down" in the weeks leading to his death. He said that the man thought he would be reconciled with his girlfriend.

37. The custody officer spoke with the man again at about 4.20pm. He said that, having been let out of his cell for dinner, the man did not collect his meal but just filled his flask with hot water. As the man walked past he said, "I'm sorry about before." The custody officer told the man not to worry and that he would see him in the morning. The man replied, "Ok boss."

38. My investigators asked the custody officer and the other officer if they had considered entering details of the afternoon's events in the man's wing history sheets. The custody officer said that he would have done so had the man been on an open ACCT. But because the man's actions were out of character and appeared to be just about a bad phone call, he did not consider that an entry needed to be made. Doing so would only make the situation worse for the man as staff would harass him, asking if everything was okay. The custody officer said he did not enter anything as "… prisoners get bad phone calls all the time …" The custody officer thought there was no need to take it any further.

39. Although the date is not confirmed, in a note addressed to his parents, the man indicates that at 7.15pm he is "… going now as I have things to do."

40. A prison officer told police that he arrived at the prison at about 8.00pm and, after a pre-shift briefing, made his way to D wing, arriving at about 8.30pm. An entry in the Staff Observation Book indicates that the prison officer arrived on the wing for his night duty at 8.00pm. At the time of the man's death, the prison officer had been in post approximately a year and it was only his second shift of night duties.

41. Although the prison officer was unable to confirm if he looked into the man's cell at the start of his shift, he told police he carried out a check of the whole wing:

    > "… one of the cells I checked was cell 59 on landing 4. The male in this cell was watching T.V. lying on his back. There were no special circumstances attached to the male in cell 59."

42. At about 9.30pm the prisoner in the adjoining cell, heard a chair in the man's cell being scraped across the floor. He told police, "… I then heard a small bang which I recognised as his door hitting the frame." The prisoner said that he thought no more of it. The prisoner told my investigators that he did not hear the man's television or any other noise from the man's cell that evening.

43. The last roll call of prisoners at Forest Bank on a Saturday is completed at 10.00pm. (A roll call is the process completed by staff at intervals

throughout the day. It involves counting the number of prisoners locked in their cell, ensuring that all prisoners are accounted for.) The Staff Observation Book for D wing records that the prison officer confirmed he had counted a roll of 87 prisoners on D wing at 10.00pm. However, the prison officer told my investigators that during the evening he realised that his radio was tuned into the wrong channel and as such had not heard the message asking for the evening roll call to be completed. The prison officer said that he therefore phoned communications and asked if the prison roll had in fact been called. The prison officer said that he panicked when told that it had. Instead of counting and checking the prisoners as required, he gave the figures recorded for the previous roll call that were written on the office notice board. He did not complete the count of prisoners himself. The prison officer said that this happened at approximately 10.30pm. (According to the communications log the prison roll was not actually called until 10.30pm and was confirmed at 10.50pm.)

44. At 00.53am the next morning (Sunday 15 July 2007), the prison officer pegged at point 4 on landing 4 on D2. His next two pegging points were both on House block D1. (Pegging is an electronic system used to record an officer's movements on a wing at night.) When the prison officer returned to D2 landing at 3.17am to peg again at point 4, he noticed that the man's cell light was on. The prison officer told my investigators that this was not unusual as some prisoners were awake at that time in the morning. However, he decided to see what was happening. (When asked if he had noticed the man's cell light being on all night, the prison officer said he had not.)

45. According to CCTV footage, the prison officer looked through the man's cell door at 3.28am. The prison officer said he saw the man hanging from the door to his right and immediately called a code yellow two. (This is an emergency code used by staff at the prison to summon assistance in response to finding a prisoner with breathing difficulties.) The communications log timed the code yellow at 3.29am. The prison officer then returned to the vicinity of the wing office, on the landing below the man's cell, to await the arrival of support staff.

46. A Senior Prison Custody Officer (SPCO) was working under the code sign Papa 1. (During the night one of Papa 1's roles is to escort staff, such as nurses, to the wings when required.) The Senior Prison Custody Officer told police that he was with a second Senior Prison Custody Officer (working under the code sign Oscar 2) in the central office when the emergency 'code yellow house block D2' was called. The Senior Prison Custody Officer told police that on their way to the wing he and the second Senior Prison Custody Officer met with a third Senior Prison Custody Officer (code sign Oscar 1). (Oscar 1, assisted by Oscar 2, is responsible for the running of the prison during the night.) At this point the Senior Prison Custody Officer changed direction in order to collect a Registered Mental Nurse (RMN) and In-Patient Manager at Forest Bank. The Registered Mental Nurse needed to be escorted from the healthcare centre as nursing staff do not carry keys at night. On their way to the

wing, the nurse, who had not been first aid trained for several years, asked the Senior Prison Custody Officer what had happened. The Senior Prison Custody Officer told him that he did not know as there had been no further updates on the radio. The nurse took an emergency bag with him. This contained treatments for minor wounds, although it was not a complete resuscitation kit. The prison defibrillator (a machine that supplies a shock to the heart in an attempt to re-start it) was located in the healthcare centre and was not taken.

47. The second and third Senior Prison Custody Officer's were met by the prison officer at the entrance to the wing at 3.30am. The three officers went to the man's cell. After looking through the observation hatch, they returned downstairs to the area outside the wing office.

48. The nurse and the Senior Prison Custody Officer proceeded to house block D2 where they were met by the three officers at 3.32am. The third Senior Prison Custody Officer told them that a prisoner had hanged himself and appeared to be dead. All three officers and the prison officer then made their way to the man's cell.

49. Using his cell key the third Senior Prison Custody Officer opened the door to cell 59 at 3.33am, approximately five minutes after the prison officer had first discovered the man hanging. The Senior Prison Custody Officer could see over the third Senior Prison Custody Officer's shoulder that the man appeared to be hanging from the hinge of his cell door.[1] His head was slumped forward. Despite some difficulty in entering the cell, caused by the fact that the man was blocking the door, the Senior Prison Custody Officer went in followed by the prison officer. The prison officer assisted in taking the man's weight and the Senior Prison Custody Officer cut the ligature from around his neck before he and the prison officer laid the man on the floor. The prison officer told police that the man, "… appeared to be lifeless, and was cold to touch." The Senior Prison Custody Officer said that the man was clearly dead. The prison officer, who was suffering from shock, went and sat in the wing office.

50. The nurse then went into the cell. He told my investigators it was clear that rigor mortis had set in. He checked for a pulse, but there was none and he felt there was little point in attempting resuscitation. The nurse requested that an ambulance be called and told his colleagues that a

---

[1] The man was housed in a normal cell on normal location and used the door pivot hinge as a ligature point. There were three similar self inflicted deaths at HMP Dovegate in mid 2002 where the door pivot was used as a ligature point.

In response to these deaths the Prison Service's Safer Custody Group and Custodial Property developed an anti-ligature door strip for use on the pivot hinges of safer cells that became available in late 2002. (A safer cell is a cell from which all obvious ligature points have been removed.)

Guidance advising prisons of the anti-ligature door strip was first issued in April 2004 and was updated in the Safer Cell Guide issued in March 2005. However, the cell in which the man died was not a safer cell and the above standards would not have been applicable.

doctor would be required to confirm the man's death. All staff present then withdrew from the cell.

51. The third Senior Prison Custody Officer said that he asked the communications room to call for an ambulance at approximately 3.30am. (The emergency contingency plans for a death in custody record that an ambulance was called at 3.29am and the communications room log that it was called at 3.33am. I attach no significance to these minor discrepancies in the timings.)

52. The Senior Prison Custody Officer and the third Senior Prison Custody Officer collected ambulance staff from the gate and returned to D2 Block with them at 4.10am. The man was pronounced dead by the paramedics at approximately 4.15am.

53. Correspondence addressed to the man's family and partner, expressing his intention to take his own life, was found in his cell. In the letters the man expressed his concern over the breakdown of his relationship.

54. In her incident statement, the second Senior Prison Custody Officer said that she logged all details of events from outside the cell from 3.25am to 7.30am. A hot debrief for staff took place at 7.30am although not all staff involved attended.

55. Later in the morning of 15 July Forest Bank's family liaison officer, met Deputy Director to discuss arrangements for notifying the man's next of kin. During their meeting they were informed that the man's mother had been told the news of her son's death at 8.15am by Greater Manchester Police. The family liaison officer contacted the man's mother at 10.00am. He introduced himself as a point of contact and offered the prison's condolences. The man's family were subsequently offered the opportunity to visit his cell and collect his personal belongings. The man's family visited Forest Bank the following Sunday. The family liaison officer attended the man's funeral. The man's funeral expenses were met by the prison.

56. The custody officer said that other prisoners on the wing were informed on the man's death that morning. He said that several of the prisoners saw the wing Listener. Staff who had been involved in finding the man told my investigators that they had been well supported by the care and welfare team at the prison.

57. A forensic pathologist conducted a post mortem at Hope Hospital, Salford. The forensic pathologist concluded that the man had died as a direct consequence of hanging and that there were no other injuries to suggest the involvement of any other person. At the time of writing, my investigator had not received the toxicological report into the man's death.

ISSUES

58. The In-Patient Manager at Forest Bank, told my investigators that all prisoners have an initial health screen, completed by either a qualified nurse or healthcare assistant, on their reception at Forest Bank.

59. The registered mental health nurse told my investigators:

> "... initial health screen in reception covers all aspects of illnesses, medications that they are on, general health, physical health and there is a section on mental health such as 'are you under mental health services', 'have you ever been admitted to a psychiatric unit' and it does look into thoughts of suicide as well."

The registered mental health nurse said that, before the introduction of VISION, health screen records completed during the reception process were not always present in the medical record. (VISION is the name of the computerised system that now records the healthcare records of prisoners.)

60. The man was asked to acknowledge on his Reception/Induction Checklist, that a medical examination would take place. However, my investigators have found no evidence to suggest that either an examination or first reception health screen actually happened.

61. The clinical reviewer confirms that there was no evidence either in the medical record or recorded electronically that the man was medically examined when he arrived at Forest Bank. In his summary, the clinical reviewer says that the extent of the man's mental illness and alcohol abuse was not fully realised until his mental health assessment on 24 April 2007.

The Director and Healthcare Manager must ensure that initial health screens are carried out on all prisoners on admission.

62. The man himself asked to be seen by a member of the MHIRT on 11 April and was seen by the mental health assessor 14 days later. During my investigation it became clear that a comprehensive and thorough mental health assessment had been completed by the mental health assessor (overseen by the registered mental health nurse) and that the man was subsequently reviewed on numerous occasions. The clinical reviewer highlights the thorough mental health assessment as evidence of good practice. He reported to my investigator that:

> "The notes of the mental health assessment appear to have flagged up 'red markers' for a suicide risk, but monitoring over the ensuing months showed a lessening of this risk, associated with a general improvement in his [The man's] health and social activities."

63. My investigators asked the registered mental health nurse if information was shared between the MHIRT and discipline staff. The registered mental health nurse said that she and her colleagues had to be careful about sharing information as much of it was medical in confidence. The registered mental health nurse confirmed that the man's state of mind was not discussed with any of the officers on his wing. The custody officer told my investigators that he was unaware the man had been in contact with the MHIRT. The custody officer was aware that the man was taking some kind of medication but, due to patient confidentiality, was not aware of the reason.

64. The clinical review concludes that whilst the man undoubtedly suffered from depression and previous alcohol abuse, medication and monitoring improved his condition over time. However, the clinical reviewer judges that there was no communication between wing staff and the MHIRT as a consequence of respecting medical confidentiality. Information sharing, in particular between medical and discipline staff, is a recurring theme for my office. Staff often cite medical confidentiality as a reason for not having shared information that, had it been communicated properly, could have assisted in keeping prisoners safe.

65. The clinical reviewer recommends that there should be a multi-disciplinary approach to those prisoners at risk of suicide or self harm and that client confidentiality should not prevent communication between MHIRT and discipline staff. I concur with the clinical reviewer's findings. It is a misunderstanding of the concept of medical confidentiality to believe that it prevents the sharing of information relevant to the safety of the patient or others. I make the following recommendation:

    The Director should ask the Mental Health in Reach Team to complete a review into the issues surrounding prisoners' risk of self harm and medical confidentiality.

66. My investigator asked the custody officer and the other officer if they had considered making an entry in the man's wing history sheets regarding their contact with the man and the fact he had received an upsetting phone call. Both said that, had the man been on an ACCT, they would have made entries on several different prison records. The custody officer said that because:

    > "… it had been about a bad phone call I didn't think it needed entering because then staff would have been harassing him and saying 'Are you ok?' and I thought it would maybe spiral the situation or make him more upset."

    Other staff on the wing were unaware of the man's behaviour because those officers who witnessed it did not record what had happened. An entry in the wing observation book would have been one way of communicating the man's actions.

The Director should remind staff of the importance of communicating significant information about prisoners both verbally and in written records.

67. When the prison officer discovered the man in the early hours of 15 July, he called an emergency code yellow 2 to summon assistance for a prisoner with breathing difficulties. During interviews with staff it became apparent to my investigators that some staff were confused about the exact meaning of the code yellow and the difference between yellow 1 and yellow 2.

68. The registered mental health nurse told my investigators about the emergency code system in use at Forest Bank. He said that in most cases staff just called a code yellow and, as a result, the codes were sometimes misused. Although I appreciate that there are no mandatory requirements to use any specific emergency code system, many prisons use a simpler emergency call system such as red (for blood loss) and blue (for breathing difficulties) codes. These inform staff of the nature of an emergency in language that is easily understood. I therefore make the following recommendation:

    The Director should consider introducing a simplified and effective system for summoning assistance in an emergency.

69. When he found the man hanging, the prison officer raised the alarm but did not enter the man's cell. He returned to the wing entrance on the landing below to meet the two Senior Prison Custody Officers. All three officers went to the man's cell and, having observed the situation, returned again to the area around the wing office. My investigators asked the prison officer if there was any reason why he did not enter the cell immediately on discovering the man. The prison officer said that he could not be sure that the man was dead and that he could have been faking the situation. The prison officer added that there were security considerations because he was on his own. (It is not unknown for prisoners to set up such a situation in order to ambush staff.) The prison officer followed the instructions of the two SPCOs on their arrival.

70. The third Senior Prison Custody Officer was asked why he did not enter the cell immediately, when both the second Senior Prison Custody Officer and the prison officer were present. He said that he would have done so had the man shown any signs of movement or breathing. The third Senior Prison Custody Officer said that, because of the way the man looked, it was obvious he had been dead for some time. When the first Senior Prison Custody Officer was asked if he had been surprised that his colleagues had not entered the cell earlier, he said that he was, but on looking into the cell himself he understood why they had not.

71. It was apparent to my investigators from their interviews with staff that some were unaware of the local procedures to be followed with regard to entering a cell at night in response to a suspected death or similar

emergency.

72. My investigator reviewed the local night instructions for dealing with a suspected death in custody. He established that the local instruction 2.87, Nights – Death in Custody/Suspected Death in Custody, lacked clarity in explaining to officers the procedures to be followed in the event of discovering a suspected suicide or death during the night. In particular, the instruction lacked guidance on when a cell should be entered and the action to be taken upon discovering a prisoner in distress.

    The Director should review Forest Bank's instructions and procedures relating to the discovery of a death or suspected death, paying particular attention to the night instructions. Attention should be focussed on when a cell may be unlocked and the staffing level that is required to do so. The Director should also ensure that all staff are aware of these instructions.

73. My investigators asked the registered mental health nurse what emergency equipment he took with him when responding to the code yellow. He said that he was only informed of the full nature of the incident when he reached the cell. The emergency bag he had with him was not a complete resuscitation kit, and only contained items for treating minor wounds. The registered mental health nurse did not take the defibrillator, which was located in healthcare. When asked if the defibrillator was something he would automatically take to a code yellow, the registered mental health nurse said, "No, because thankfully, touch wood, it's very, very few times that we need it, and if people need a defibrillator I would be getting an ambulance in anyway."

74. The clinical reviewer asked why the defibrillator did not form part of the emergency pack. The registered mental health nurse said that it was probably "not a good idea" and there was "seldom need to use it anyway." The nurse added that he was "mental health trained not a first aider". He believed some of the nurses had been trained to use the defibrillator "… several years ago, but certainly not recently."

75. The clinical review states there is no point having equipment in the healthcare centre if staff have not received appropriate and updated training on how to use it. I agree that Forest Bank should address this clinical governance issue and provide appropriate training.

    The Director and Healthcare Manager should satisfy themselves that night duty staff, especially medical staff, have adequate first aid and defibrillator training and are aware of their location in the prison.

    The Director and Healthcare Manager should consider the optimum number and location of defibrillators in the prison.

    The Healthcare Manager should review the contents of the

emergency bag, ensuring that appropriate equipment is available.

76. The ambulance was not called until 3.33am after staff had entered the cell cut the man down and checked for signs of life. The registered mental health nurse conceded that he did not ask for an ambulance to be called until staff had cut the man down. The registered mental health nurse pointed out that any member of staff could call an ambulance if they thought that one was needed.

77. The third Senior Prison Custody Officer told my investigator that he awaited the registered mental health nurse's instruction before calling for an ambulance, as it was not something that he would do "off his own back". He said that an ambulance would not automatically be called after a code yellow as the code could just relate to a superficial injury. The third Senior Prison Custody Officer explained that any incident requiring medical assistance was called a code yellow.

78. A letter to Governors from the Director of Prison Health in March 2004 advised that it was the responsibility of Governors to ensure a protocol existed to facilitate immediate access to paramedic services. The letter advises that:

> "It is also essential that internal procedures should not waste undue time in summoning emergency assistance. It should not; for example, be a requirement in every case for a member of the Health Care Team to attend the scene before Emergency Services are called. However, a subsequent 999 call to the Ambulance Service should be made to cancel the response if, after the original 999 call has been made, a member of the Health Care Team arrives with the patient and deems that an emergency ambulance response is not required."

The Director and Healthcare Manager should ensure that a local protocol is in place that provides clear advice about situations in which the Ambulance Service should be called.

79. In their feedback to the Director, my investigators expressed concern about the generally poor quality of entries in wing history sheets and other records, many of them being formulaic. Although I make no formal recommendation, the Director will wish to ensure that staff to engage in constructive dialogue with prisoners and make full and accurate entries in all prison records.

80. My investigators have also drawn to my attention the poor quality of post incident reports/statements completed by staff who responded to the man's death. Again I make no formal recommendation but ask the Director to remind staff of the importance of completing comprehensive and accurate statements. All staff involved when a prisoner dies suddenly should be invited to attend the hot debrief.

81. Although the Senior Prison Custody Officer was not first on scene, and he was not responsible for managing the situation, I commend the immediate and effective actions that he took once he reached the man’s cell.

RECOMMENDATIONS

Director

1 The Director should ask the Mental Health in Reach Team to complete a review into the issues surrounding prisoners' risk of self harm and medical confidentiality.

Accepted – Local Safer Custody Team to discuss with in-reach team and amend suicide prevention policy.

2 The Director should remind staff of the importance of communicating significant information about prisoners both verbally and in written records.

Accepted – Staff information notice to be published to remind staff of importance of communicating any issues. All residential managers now check 10% of all files monthly and Head of Regimes checks they take place.

3 The Director should consider introducing a simplified and effective system for summoning assistance in an emergency.

Accepted – Implementation of system of CODE RED for bleeding and CODE BLUE for breathing issues to be discussed with SMT and COMMS meeting.

4 The Director should review Forest Bank's instructions and procedures relating to the discovery of a death or suspected death, paying particular attention to the night instructions. Attention should be focussed on when a cell may be unlocked and the staffing level that is required to do so. The Director should also ensure that all staff are aware of these instructions.

Accepted – A full review of night procedures to be carried out also a review in to the procedures for staff entering cells in night state. Any changes to be published on the LSS and cascaded to staff via information notices. Local Safer Custody Team to assist with procedures when entering cell in night state due to self harm or suicide attempt.

Director and Healthcare Manager

5 The Director and Healthcare Manager must ensure that initial health screens are carried out on all prisoners on admission.

Accepted – All prisons entering Forest Bank complete initial health screening whilst in reception and before locating on the induction wing.

6 The Director and Healthcare Manager should satisfy themselves that night duty staff, especially medical staff, have adequate first aid and defibrillator training and are aware of their location in the prison.

Accepted –

7 The Director and Healthcare Manager should consider the optimum number and location of defibrillators in the prison.

Accepted – There are 3 defibrillators on site. They are located in the reception, healthcare and in the central hub of the prison.

8 The Director and Healthcare Manager should ensure that a local protocol is in place that provides clear advice about situations in which the Ambulance Service should be called.

Accepted – A local protocol will be completed to provide clear advice concerning when an ambulance can be called and by whom.

Healthcare Manager

9 The Healthcare Manager should review the contents of the emergency bag, ensuring that appropriate equipment is available.

Accepted – A review of contents of emergency bag will be carried out and finding reported on.