Investigation into the circumstances surrounding the death of a man at HMP and YOI Onley in August 2005

Report by the Prisons and Probation Ombudsman for England and Wales

January 2007

This is the report of an investigation into the death of a man at HMP and YOI Onley in August 2005. The man, who was 30 years of age, was found hanging in his cell.

My colleagues and I offer sincere condolences to the man's family and friends for their sad loss.

On 7 January 2005, the man had been sentenced to 42 months imprisonment having been convicted of possession of Class A drugs with intent to supply. He was transferred between HMP Woodhill and Onley for short periods following his sentence until he was finally located in Onley on 22 February 2005.

The investigation was led by my colleague. I am grateful for all the assistance that the investigation team received from the then Governor of Onley and her staff, including the Deputy Governor, who acted as the establishment's Liaison Officer.

A key objective of all my investigations is to ensure that the bereaved family has the opportunity to raise any concerns and can contribute to my inquiries. I am grateful to the man's family for agreeing to meet with the investigation team at what must have been a very difficult and distressing time. I regret the delay in completing this report.

STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN **JANUARY 2007**

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SUMMARY

1. The man was 30 years old, he had been convicted and sentenced to 42 months imprisonment in January 2005 on drugs charges. He was initially located in HMP Woodhill until he was transferred to Onley on 18 January. Following a further court appearance in February 2005, the man returned to Woodhill until 22 February 2005 when he was transferred back to Onley.

2. There was no past medical history of note during the reception healthcare checks on 7 January, 18 January, 11 February or 22 February. The Prisoner Escort Records (PERs) that were completed for these transfers do not note any concerns or that the man had any suicidal or self harm intentions.

3. The man maintained contact with his partner through regular visits, telephone calls and letters. He was known by wing staff to be having difficulties in his relationship, and these appear to have worsened in the period leading up to his death. A Suicide and Self Harm form (F2052SH) was opened on 31 July, and closed shortly after on 1 August.

4. The man volunteered to become a Listener (a prisoner who is trained by the Samaritans to help other prisoners who are having difficulties). He performed the role for a brief period until 2 August when it was felt that it might be too stressful for him in view of his own personal problems.

5. On 8 July, the man was considered suitable for re-categorisation from Category C to Category D. It appears that he was looking forward to going to an open prison as soon as arrangements could be made. Unfortunately, this was not achieved before he was tragically found hanging in his cell on 9 August 2005.

CONDUCT OF THE INVESTIGATION:

6. I appointed a lead investigator from the Prisons and Probation Ombudsman. She was assisted by another of my investigators.

7. During the course of initial inquiries, the investigation team were shown around Onley and visited the cell where the man died. They reviewed all the relevant documentation and established a chronology of events. Notices were issued to staff and prisoners telling them of the investigation and offering them the opportunity of contributing. There were no responses to these notices.

8. One of my Family Liaison Officers contacted the man's family and offered them the opportunity to meet with him and my lead investigator to discuss the purpose of the investigation and to raise any concerns or questions that they would like explored and addressed. They met with the man's mother, sister and partner on 9 September 2005. In a separate meeting the same day, they met with the man's father. The man's sister also attended that meeting.

9. The family raised a number of concerns about the man's mental health in the days leading up to his death. They wanted to know why prison staff apparently did not notice or act upon his increasingly distressed state, and why he was taken off what they called 'suicide watch' (the F2052SH procedures) on 1 August after only 24 hours. There were questions about the manner of his death and how he was able to obtain the shoe laces he used.

10. The man's mother said her son had been prescribed anti-depressants for some time, and had been considered unfit for a custodial sentence at a previous trial. She asked why his medication had not then been continued when he was admitted to Onley. She also asked why, given his mental health at the time, he was allowed to become a Listener, a role that she feels he found emotionally upsetting. The man's mother also wondered if there was any evidence of his being bullied at Onley. She said that, on the Tuesday before he died, he asked a member of staff if he could use the telephone to make a relatively long call. She believed that, given this information, staff must have known that her son was in a distressed state and could have taken more action. Finally, the man's mother questioned why none of the family was told that he had been placed on a 'suicide watch' on 31 July. The man's father expressed concern that his son was not on a 'suicide watch' at the time of his death. He was also upset that he was not told about his son's death by the prison, but learned of it from his daughter. These concerns and questions raised by the man's family are examined further in this report.

11. The investigation team met a representative of the local branch of the Prison Officers' Association (POA), and a representative of the Independent

Monitoring Board (IMB), to tell them about the investigation process. Fifteen members of staff were interviewed during the course of the investigation. They were all offered the opportunity of being accompanied by a work colleague or Trade Union official.

12. The investigation team also met with a prisoner who had spoken to the man in his capacity as a Listener.

13. The investigation team contacted Her Majesty's Coroner to tell him of the nature and scope of the investigation. The Coroner kindly provided a copy of the post mortem and toxicology report of 11 October 2005. The post mortem report recorded the cause of death as ''hanging".

14. A doctor undertook a clinical review of the healthcare provided to the man while at Onley.

15. As a result of feedback from the Prison Service and the man's family to the draft report, changes have been made to correct some factual inaccuracies and to further clarify certain points. These changes have been detailed in separate letters to those concerned.

BACKGROUND INFORMATION

HMP and YOI Onley

16. Onley opened as a Borstal in 1968 and became a prison for young offenders in 1976. Its capacity rose from 420 to 520 in 1991 with the addition of new accommodation, and further increased to 640 in 1998 when two more wings were added. For a period, the establishment held a mixture of young offenders and juveniles. In 2004, the prison was re-roled as a Category C adult prison and Young Offender Institution (YOI). At present, one wing is closed as part of a refurbishment programme which is due to be completed this year. Onley had an uncrowded capacity of 580 as of 21 March 2005. It is a Category C establishment accepting all suitable determinate prisoners, who have been sentenced by the courts. All residential training wings apart from I Wing have 60 single cells - each with internal sanitation, in-cell electricity and TV. J and K Wings accommodate adults and young offenders with resettlement needs. G and H Wings are the induction wings. D and E Wings are the Drug and Alcohol Support Units (DASU) for young offenders and adults respectively. I Wing holds 100 prisoners in 50 double cells all with internal sanitation.

17. The local strategies for the care of prisoners at risk of self-harm at Onley are in accord with national policy. The local policy for the prevention of suicide is published within the prison and is available to both staff and prisoners.

THE MAN'S TIME AT ONLEY

18. After sentencing in January 2005, the man was initially sent to HMP Woodhill where a full induction procedure was conducted. A first reception healthscreen was undertaken by a nurse who noted that the man had no medical complaints apart from corns on his feet. It was also noted that he had last used cocaine/crack and cannabis the day before and that he used cocaine/crack weekly. The reception healthscreen form, section 10 says: 'if using a) to e) - a)heroin, b)methadone, c)benzodiazepines, d)amphetamine or e)crack/cocaine more than once a week or positive urine test, refer to doctor for symptomatic relief and Detox Unit'. The clinical lead for Woodhill confirmed to the investigation that the man did not have a urine test, and was not referred to the Substance Misuse Service, as they do not routinely see prisoners who do not have an opiate, benzodiazepine or alcohol dependence. No further action was considered necessary following the healthscreen. He was not referred to a doctor or to any other specialist service. The Prisoner Escort Record which accompanied him from the court did not note any issues or concerns of self harm or suicidal intentions. The Cell Sharing Risk Assessment recorded that he was a low risk of sharing a cell with others and was suitable for multi-cell location.

19. On 18 January 2005, the man was transferred from Woodhill to HMP Onley where he was located until 11 February. A reception healthscreen was undertaken by a nurse who noted in the man's medical record that she took his blood pressure and pulse. The only notes from that healthscreen are that the man said he was content to be at Onley and had no thoughts of self harm. The Head of Healthcare explained that her understanding was that, although there was a pro-forma reception screening tool available at Onley at this time, it was not being used by healthcare staff as they felt it was not user-friendly. Healthcare staff were verbally assessing the health of prisoners with a series of questions about their physical and mental health and summarising the answers. The issue was raised at a staff meeting on 9 September 2005 as poor practice, and staff were instructed to resume using the pro-forma. After that date, every prisoner was screened using a pro-forma and a new screening pro-forma has subsequently been designed. The PER which accompanied the man from Woodhill to Onley did not note any concerns regarding self harm or suicidal intentions, but did record that he had drugs problems. The Cell Sharing Risk Assessment showed that he was a medium risk (no immediate risk from sharing a cell with others but the situation would need to be reviewed regularly).

20. On 11 February, the man returned to court, and was subsequently located in Woodhill again until 22 February. A reception procedures checklist was completed for him and noted that he was seen by healthcare. The healthscreen note lists a number of medications for his corns. A Cell Sharing Risk Assessment was completed. This showed that he was a low risk, and was suitable for multi-cell location. It was noted that he had abused cannabis, but no other details were recorded. There is no trace of a PER to accompany him from the court on this occasion. On 22 February, the man was transferred back to Onley from Woodhill. He underwent another reception

healthscreen, as a transfer prisoner and a note in his medical record states, 'to see MO (medical officer) re foot. Appointment to be made otherwise fit and well.' The PER which accompanied again him did not note any concerns about suicide or self harm, but noted he had drugs problems. The Cell Sharing Risk Assessment recorded that he was a medium risk. A box was ticked that he had not abused drugs or alcohol (despite the information on the PER). The man was not identified as being depressed or suffering from any mental illness during any of the healthscreens undertaken at Woodhill or Onley and his GP records were not obtained. There is no evidence that he told anyone that he had been suffering from depression and had previously been prescribed anti-depressants.

21. After completing induction on 25 January 2005, the cell share risk assessment indicated that the man was a low risk of sharing a cell with others, and he was initially located on I wing in a double cell. The man then applied to move on to E Wing to address his substance abuse. He was located on DASU, a dedicated Drug and Alcohol Support Unit for adult prisoners, on 31 March 2005. Nothing of note happened until 28 April 2005 when he fell or fainted in his cell and hit the back of his head. A prison doctor examined him and he complained of vomiting, headache and dizziness. He had a small swelling to the back of his head, and was prescribed paracetamol and told to rest in his cell for the rest of the day

22. On 6 June, there is a note in the man's medical record that he asked a nurse (whose signature is illegible) to recommend him to be sent to a Category D establishment. It was noted positively that he had completed a smoking cessation course and a Story Book Dads project (and had been interviewed on the radio about that). The nurse felt that in the circumstances a recommendation for re-categorisation was appropriate. On 8 July, the man was classed as suitable for re-categorisation. The prison was looking to transfer him to HMP Spring Hill, a category D open prison.

23. On 14 July, there is an entry in the Wing Observation Book, written by an officer, 'the man was quite distressed as argument with girlfriend re going away with her little girl.' The man was allowed to make a public expense telephone call to his girlfriend. **(**According to PSO (Prison Service Order) 4400, Chapter 4, prisoners can use official telephones if there are urgent legal or compassionate circumstances such as imminent court proceedings or a domestic crisis. Operational Managers have discretion to authorise these calls and did so for the man.)

24. On 16 July, there is an entry in the man's core record, written by the same officer, 'Requested to go to Spring Hill, needs to pass ROTL board (release on temporary licence) to travel there himself, but seems happy for transport to be arranged for him.' On 28 July, there is a note by the prison doctor that the man consented to have his moles removed from his face and they were removed under local anaesthetic. He also had a cyst removed from under his right arm which was sent for further investigation. On 29 July a principal officer (PO) made an entry in the man's core record that he had been downgraded from enhanced to a standard regime, after being caught handing

tobacco to another prisoner. He appealed against this and was reinstated to the enhanced regime on 2 August.

25. On 31 July, there is an entry in the Wing Observation Book by a second officer that the man asked to speak to a Listener. Another entry by the same officer said, 'further to the man asking to see a Listener, problem is that common law wife is threatening to end the relationship. The man was very upset but the Listener said that he did not think the man was suicidal.' The Listener said in interview that he spoke to the man. He said that he saw marks around the man's neck and he was crying and eventually he told him that he had tried to commit suicide that night. The Listener said the man told him that he had used laces to try to hang himself and that he immediately took the laces from the man. He told an officer that the man had tried to kill himself. He said that the man had marks around his neck and, although he did not specifically explain how he had got the marks, the man said he had tried to hang himself twice.

26. When this report was produced in draft, the Head of the Safer Custody Group expressed some concern about the Listener's understanding of his obligation in terms of confidentiality. The Head of Safer Custody Group said:

> 'The principle of confidentiality is central to the work of Samaritans and Listeners. We think it has saved numerous lives. Without an assurance of confidentiality prisoners may not feel able to approach Listeners and talk freely about their feelings in an atmosphere of total trust. Sharing information with staff without prisoners' consent would jeopardise the viability of Listener schemes and negate their considerable value. Listeners are trained to encourage prisoners, with Listeners' support, to speak to staff about their anxieties and share information. Whether or not information has been shared with staff, staff will of course know which prisoners have asked to see Listeners and therefore who might be at risk. All information is confidential to the Listeners and Samaritans unless: a) Listeners have the contact's informed permission to pass on the information (which does not appear to have been the case here); b) The contact is attempting suicide or serious self-harm in the presence of the Listener. The Listener must tell the contact what will happen if he/she persists; c) The contact attacks or threatens the Listener, or the Listener is given information about acts of terrorism or bomb warnings; or d) the Listener receives a court order (subpoena) requiring him to divulge the information.'

27. The Safer Custody Group has subsequently ascertained that the member of staff to whom the Listener spoke was also a Samaritan. Consequently, the Listener believed he could offload his concerns about the man to the member of staff in her role as a Samaritan in confidence. The Listener did not believe he was not breaking confidentiality, and it does not appear the member of staff told the Listener that she had a duty, as a member of staff, to record and pass on her concerns about the man's vulnerability. Subsequently, when she did so, this too was a breach of his confidence. It appears that there was a

significant conflict of interest for the member of staff between her roles as an officer and a Samaritan.

28. The correct way for a Listener to 'offload' is either to another Listener or to the Samaritans by phone or in person. I understand that the relevant Samaritans branch has now advised the officer she should make it clear to any Listeners that she cannot accept any information they wish to pass on in confidence. Listeners maintain confidentiality even after the death of a caller and if a Listener is required to attend an inquest Samaritans will be available to support the Listener through the hearing.

29. The second officer said in interview that he responded to a cell bell call from the man's cell at around 1.20pm on 31 July 2005. He said that he appeared agitated and asked to speak to the Listener. The officer felt that the man was concerned about his relationship with his partner and he spoke to his colleague, the officer who was also a sarmaritan, about the situation. He recalled that the man subsequently spoke to the Listener for approximately 10-15 minutes. After that, the colleague spoke to the man and the second officer spoke to the Listener.

30. According to the second officer, the Listener told him that the man had tried to kill himself but, in the Listener's words, he had 'chickened out'. (In his interview, the Listener does not mention talking to the second officer.) The second officer said that he then spoke to the man and said to him, 'I know you are not going to like this but I have concerns about you … I am going to put you on a 2052 [F2052SH].' He said that the man was angry and indignant and insisted that he was not suicidal. The second officer said he pointed out to the man that he had a mark around his neck, but the man said he had been playing with the key chain and this seemed plausible to the second officer. (Prisoners have their own courtesy cell keys which are attached to a heavy fabric 'chain' which they generally wear around their necks. They use their keys to go back into their cells when they are unlocked at specific times during the day for association etc. Once back in their cells, the cell doors are double locked.)

31. The officer who was also a samaritan said in interview that the Listener approached her and said he was concerned about the man because he seemed a bit upset and had told him that he was thinking of taking his own life. She said that she and a senior officer spoke to the man. He told them that he was just a bit upset and wanted to go home, and denied that he was thinking of taking his own life. She said that she saw a red line on his neck and asked him how it had happened. He told her that he had been rubbing his 'key chain' around his neck, which in her opinion was a feasible explanation. She explained that the man's categorically denied that he was thinking about harming himself and was annoyed about being placed on the F2052SH. Her account is confirmed by the senior officer. The senior officer also said that the man asked to speak to the police liaison officer within the prison, about giving him information. The senior officer said that he e-mailed the police liaison officer with a request to see the man over the next few days. The man spoke to the prison liaison officer on 4 August. There is no record of

this conversation and this police liaison officer is no longer at Onley. He has failed to respond to my investigation team.

32. An entry in the Wing Observation Book by the second officer on the same day reads, 'came to light that the man had attempted to hang himself but had "chickened out" at the last moment. 2052SH opened and Healthcare informed.'

33. On 31 July, staff also contacted a nurse, who saw the man on the wing. The nurse said in interview that the man told her his partner had said she wanted to end the relationship. The nurse said that the man was anxious to get out of prison as quickly as possible to see his partner, and talk to her to resolve the situation. He told the nurse that he had been given a date for transferring to a Category D prison which was weeks away. She said that she explained to him that he might get released earlier if he joined the HOPE Project. This is a structured programme that helps drug users to re-settle successfully back into the community, by providing support from agencies like the Police, Drug Services and the Probation Service.

34. The nurse said that the man did not show any signs of depression and in fact denied any intention to harm himself. She said she returned to see the man 45 minutes later with information about the HOPE project, when he told her that he had spoken to his partner again. Their problem had apparently been resolved and he was a lot happier. He told her that he did not want to be on the F2052SH and was looking forward to being transferred to an open prison. The nurse considered that the F2052SH was no longer necessary, and confirmed that she did not recall seeing any marks on the man's neck. She said she was not told about the marks by any members of staff. She noted on the F2052SH at 3.15pm that the situation was resolved as the man said he was not suicidal and did not have any intention of self-harm.

35. Also on 31 July, the second officer made an entry in the Wing Observation Book recording that the man had been seen by a healthcare nurse who did not think that the F2052SH was needed. Despite this, the man remained on the 2052SH and the second officer noted that the situation would be reassessed the next morning.

36. On 1 August, the prison doctor saw the man. She noted that the F2052SH had been opened after an argument with his partner which had since been resolved, and that he had no thoughts of self harm and did not want to remain on the F2052SH. Her recommendation was that there was no need for him to be on the F2052SH. There is an entry by the second officer in the Wing Observation Book which notes that the man's 2052SH was closed after a review. The entry reads, '2052SH closed after Board. Staff names were noted. The second officer confirmed in interview that the nurse was not physically present at the review to close the 2052SH.

37. The second officer said that he spoke by telephone to the doctor on duty who said he was busy, but he was happy for the man to be taken off the F2052SH. He also spoke to the review nurse by telephone who told him she was also

content for the man to be taken off the 2052SH. This nurse does not recall any such telephone call. It is therefore not clear what healthcare input there was in the review which was held to close the F2052SH. As noted, those present were discipline staff: The SO, PO and second officer. The review, written up by the SO, said It had been agreed that with the improvements in the man's demeanour and behaviour, coupled with the improvements in his family relationship, there was no need for the file to remain open. It was closed at 11.20am, less than 24 hours after it had been opened. The Suicide and Self Harm Strategy for Onley notes at paragraph 17 that there is no instruction about which members of staff must contribute to or be present at a case review. The Governor may wish to consider whether to require that there should always be input from healthcare into case reviews.

38. The review PO confirmed that he was content for the F2052SH to be closed as the man was adamant that he was not going to harm himself and did not want to be monitored. He said that an officer, probably the second officer, phoned healthcare and they told him they were content for the F2052SH to be closed. He said that, if there had been any concerns about the man, healthcare would have been asked to attend to make an assessment face to face. He explained that he was not aware of any marks around the man's neck. The review SO agreed with this account.

39. Neither the man's partner nor his family were advised by the prison that he had been placed on a F2052SH. At 7.38pm on 1 August, the man made a telephone call to his sister, a transcript of which records that he told his sister he had thought about hanging himself the previous day. On 2 August, the man had a tearful telephone conversation with his partner at 8.00am, during which he said he was feeling very low and had not slept for two days. There is an entry in the Wing Observation Book with an illegible signature which reads, 'Listeners are not to move wings. Some pressure from H wing Listener exerted on the man. The man has family issues.' Following this there is an entry by the second officer in the Wing Observation Book that under no circumstances was the man to be used as a Listener - by order of the SO in charge of the Listener scheme. The second officer explained in interview that initially the man coped well with being a Listener, and feedback was positive. However, he said that he became concerned that the Listener role might be putting extra pressure on him, as the man's relationship with his partner appeared to be deteriorating. The second officer said that he spoke to the SO in charge of Listeners about his concerns and the man was immediately taken off the Listener scheme. I believe the Samaritans stood him down.

40. The prison doctor saw the man on 8 August and there is an entry in his medical record which states 'seen on 8 August following on from removal of two moles, the area appeared red and Betadine was applied'. He had also had a cyst removed from under his arm, which the prison doctor's report of 9 August confirms was benign.

41. On 8 August, the man made a number of telephone calls to his partner. It is noted that at 10.09am, he had a tearful argument with her about whether she wanted to be with him any longer. He called her back at 10.14am and

10.17am, and she put the phone down on him on both occasions. He called her again at 12.02pm and she said that she would book a visit for Sunday. An SO said that he authorised a public expense call for the man at 4.50pm, then the man made a short telephone call to his partner in the main wing office in his presence. The SO said that the telephone call lasted for a couple of minutes and the man did not seem distraught or upset during or afterwards.

42. A police interview with a prisoner confirms that, at tea time on 8 August, the prisoner gave the man laces from a pair of trainers which he was not using as the man told him the laces in his trainers were broken. There is no evidence that any member of staff was aware that he had been given these laces.

EVENTS OF 9 AUGUST

43. On 9 August at around 1.30pm, two officers started unlocking prisoners who were due to go to activities such as education and gym. They arrived at the man's cell at around 1.40pm. One officer unlocked the door as the man had asked to go to basketball. However, the man told him that he no longer wanted to go because his arm was hurting from the operation to remove the cyst. At the man's request, the officer let him get a cigarette from his neighbour's cell. He heard him ask for a cigarette and assumed he had one and then secured him back in his cell.

44. A further roll check was undertaken by the two officers at 2pm, and the man asked the second unlocking officer if he could have some toilet roll. The officer told the man that he had a couple of things to do and would return in about five minutes with the toilet roll. The man pressed his cell bell at 2.14pm to ask again for a toilet roll. The officer fetched some toilet roll from an empty cell and headed to the man's cell with it. The other unlocking officer passed him on the stairway and he confirmed that the toilet roll was for the man and handed it to the man in his cell. He did not appear distressed or upset. Both officers did not recall seeing any shoe laces attached through the grill of the air vent above the cell door at this time. One of the officers explained that, if there had been shoe laces attached in that way, they would have been in his line of sight and he would have noticed them.

45. At around 4.10pm, the same two officers started unlocking prisoners before tea. The second unlocking officer said he looked in through the observation hatch in the man's cell, as his cell was the only one which was still double-locked, and he saw the man's back and right shoulder against the inside of the door. He said he unlocked the door and as he began to open the door, which opens inwards, he could feel resistance. He explained that he opened it sufficiently to take a step inside when he looked around the door and saw a lace attached through the air vent grill at the top of the cell door with another lace attached to that as a ligature around the man's neck. He noticed a slippery substance on the floor, which was later found to be butter or margarine. He explained that he went out of the cell and immediately called the other unlocking officer for help. The other unlocking officer put out an urgent message by radio for healthcare assistance.

46. The other unlocking officer then went back to the cell and stayed outside the cell with the officer who was also a Samaritan, who had arrived in the meantime. The SO who authorised the public expense call and a second SO were in the E wing office when they heard the emergency call and they responded immediately and arrived together at the man's cell. The SO who authorised the public expense call went into the cell first followed by the second SO and then the unlocking officer went back into the cell. A third officer had also arrived by then and stood in the doorway with the officer who was also a Samaritan.

47. Before he entered the cell, the second SO heard the SO who authorised the public expense call ask the third officer to get a fish knife (these are located in

sealed boxes in every wing office) to cut the ligature. The second SO then entered the cell and supported the man's body with the assistance of the SO who authorised the public expense call. One of the unlocking officers and the officer who is also a samaritan went to fetch a fish knife from the main office on E Wing. Before they returned, A nurse appeared at the cell door and passed her ligature scissors, which were attached to her security chain, to the second unlocking officer who cut the ligature under the second SO's instructions. The man was then laid on the bed. No resuscitation was attempted as in the nurse's opinion he was already dead.

48. The man was pronounced dead by the prison doctor at 4.20pm. The cell was sealed at 4.30pm. At 10.02 pm, undertakers arrived and removed his body from the cell to the local infirmary.

49. The second unlocking officers said he was surprised that the man was able to attach the laces through the air vent grill, as the gaps are small and, in his opinion, not large enough to push a finger through. The second SO said that some prisoners on A Block have been known occasionally to make laces into hangers for the back of their cell doors to hold food and other items in bags. He has since told his staff to tell prisoners to take these down if they see them.

EVENTS AFTER THE MAN'S DEATH

50. Shortly after the man's death staff wrote incident reports. Onley's emergency orders for dealing with a death in custody and role briefs require the Duty Governor and Orderly Officer (PO) to ensure that all witnesses remain in the vicinity for taking of statements. There are no incident reports or statements from the second unlocking officer, the officer who was also a samaritan or the nurse who attended the scene.

51. The man had named his partner as his next of kin and she was visited by the Governor, the police liaison officer and one of the prison chaplains. The man's family visited the prison on 25 August and were able to see his cell and speak to prisoners who knew him. The Governor sent a letter of condolence to the man's family and offered to contribute to the funeral costs in line with Prison Service Order PSO 2710.

52. Prisoners on E wing organised a collection and bought flowers. A memorial service was held at the prison on 10 August. It was open to all prisoners and staff to attend. I understand that all staff and prisoners from E Wing and some staff from education and healthcare were present.

53. The man's father was not informed of his son's death by the prison and was told by his daughter, who in turn had been told by the police. He subsequently visited the prison. According to the PO who spoke to him, he was understandably very upset and wanted answers to questions. This PO noted in his incident report that he told him that the man's body had been taken to the local Infirmary and that the man's partner had been informed of his death as his nominated next of kin. The PO also noted his contact telephone number and told him somebody from the prison would liaise with him in due course. I am pleased to record that this commitment was honoured.

54. Support for discipline staff who were involved was offered through the prison's care team and chaplain. However, one member of staff was not initially approached by the care team and felt that the support from the prison was poor. Other staff generally felt they were not supported as effectively as the prisoners.

CLINICAL REVIEW

55. The investigation team advised the relevant Primary Care Trust (PCT) of the man's death on 15 August 2005. The PCT then arranged to undertake a clinical review of the healthcare provided to him while at Onley. The reviewers report concludes that the man did not show any suicidal intentions after the initial concern on 31 July: 'despite the confusion over the closing of the 2052SH and the lack of reporting the bruising around the man's neck, it is unlikely that his suicide could have been predicted and prevented but that the information on the 2052SH was incomplete.' He also concluded that healthcare staff do not have any suicide risk assessment training and do not undertake significant event reviews after such tragedies. It was also clear that healthcare staff did not have adequate support after the man's death. The clinical review makes two recommendations:

Training for identification for suicide risk and significant event analysis should be offered to all healthcare staff.

Staff should be offered support, both emotional and in the form of a significant event review following an incident such as this.

CONSIDERATIONS AND CONCLUSIONS

56. The healthcare reception screenings which the man received as a transfer prisoner to Onley on 18 January 2005 and 22 February 2005 do not appear to have been comprehensive. I am pleased that since September 2005 a pro-forma checklist (which has recently been amended) is routinely used to complete a reception healthscreen for all prisoners arriving at Onley.

57. The man's family questioned why he was not prescribed anti-depressants when he arrived at Onley, as he had previous history of depression. However, it is clear that the man did not declare that he had any mental health problems or that he suffered from depression during any of the reception healthscreens. As a result, his GP medical records were never obtained as there was no apparent reason to do so.

58. The man's family expressed concern about him being a Listener. The Listener scheme is well established within prisons. Prisoners volunteer to undertake the role and if considered suitable they undergo comprehensive training by the Samaritans. They are supported by the Samaritans and regular weekly debriefs are undertaken. The man undertook the training and there were no concerns initially about his ability to cope. He was taken off the scheme immediately when staff felt it was not appropriate for him to continue due to his own personal problems. I believe he was also stood down by the Samaritans.

59. From the evidence of staff and a Listener, the man appears to have had a troubled relationship with his partner throughout his time in Onley, Staff were aware that the telephone calls to his partner were important and there is evidence that he was allowed to make at least two public expense telephone calls. Notes in his core record show that staff were also aware that the telephone calls the man had with his partner did not always go well and the effect that sometimes had on him.

60. The man was placed on a F2052SH on 31 July after he spoke to a Listener who expressed concerns to staff. This was closed less than 24 hours later and it is unclear whether there was any healthcare input in closing the review. There is evidence that the man had marks around his neck and told the Listener that he had tried to kill himself. However, he told staff that he had no intention of harming himself and the marks were from his key chain rubbing on his neck.

61. The man's mother asked whether another Listener, apart from the one mentioned in this report, spoke to the man. The investigators ascertained that another Listener did speak to him. However, the prison has no record of when this was or what was discussed as the meeting was confidential. The Listener has subsequently been released from prison and was not contacted. The man's mother also raised concerns that some statements mention that an the unlocking officer asked staff to keep an eye on her son. It is not clear whether this was to do with the man becoming upset when this officer spoke

to him about contacting his father. In their initial interviews, my colleagues did not ask the stated officer specifically about the issue. Consequently, my investigator spoke to the unlocking officer again on Friday 8 December 2006 to clarify this point. He explained that the man did not show any signs of concern when he spoke to him about having contact with his dad, but the officer wanted staff to be aware that the man's behaviour might be different during the day and 'be a bit off'. He did not want the man to get into trouble. The officer could not recall exactly what he said or whom he said it to, and thought he might have made a general comment in the expectation that staff would be more sensitive towards him. The officer explained that nothing else of concern or note happened that morning.

62. I agree with the clinical review that that it is unlikely that the man's death could have been predicted and prevented. However, his mother's solicitors noted that the Wing Observation Book recorded that the man had attempted suicide whereas the F2052SH mentioned only the marks on his neck and did not suggest he had attempted suicide. I think the F2052SH may have been closed prematurely and judge that the man's explanation for the marks around his neck were accepted too readily, without further exploration or concern. The Governor may wish to consider reminding staff of the importance of completing paperwork accurately, including all relevant information.

63. It is not clear what healthcare input there was in closing the review. I am aware that the there is no requirement in Prison Service Order 2700 that a member of healthcare staff must contribute to or be present at the case review. The PSO says that 'The F2052SH will be closed at a case review when the prisoner appears to be coping satisfactorily. When deciding on closure, the chair of the case review must be a minimum grade of SO or Nurse Grade F'.

64. There is also no requirement in PSO 2700 that a prisoner's family should automatically be notified if they are placed on a F2052SH. It is an option when completing the support plan - if appropriate and with the prisoner's agreement. Section 3.4.3 of PSO 2700 concerns incidents when prisoners have self harmed and states, 'after consultation with the prisoner, the nominated next of kin must be notified, unless: there is a clinical reason not to, or if aged 18 and over, the prisoner does not consent, or the prisoner's support plan indicates otherwise (e.g. in the case of a prisoner who repetitively self-harms).' Section 3.4.4 states, 'where appropriate, after serious incidents of self-harm consideration should be given to allowing the prisoner themselves the opportunity to notify the next of kin by a phone call and/or an extra exceptional visit.' In the man's case he denied categorically that he had self harmed.

65. The Prison Service is in the process of rolling out a new system of support and monitoring for prisoners at risk of self-harm: Assessment, Care in Custody and Teamwork (ACCT). At Onley, all residential and resettlement staff have now been trained in the use of the new system which is designed to assess and manage risk more effectively with a greater input from the

prisoner and other members of the multi-disciplinary team.

66. The man's family were also concerned to know if he was bullied or intimidated by other prisoners. My investigation found no evidence that he was bullied or intimidated. No complaints were made by him to any member of staff. He had spoken to a senior officer about contacting the police liaison officer, to give him information, but indicated this concerned matters outside the prison. In the event, the man spoke to the prison liaison officer, in confidence, on 4 August. However, as previously discussed, the prison liaison officer did not make a record of the conversation and it has not been verified.

67. The man's family asked why he was allowed to have shoe laces. There is no evidence that staff were aware that a prisoner had given him shoelaces, and no instructions that the man was not to have shoe laces of his own. Paragraph 22 of the local Suicide and Self Harm Strategy August 2005 states, 'shoelaces, belts, cutlery and other personal items should not be routinely removed from at-risk prisoners. Depriving prisoners of such items and drawing attention to them in the process can worsen the distress of those who are already vulnerable. Prison staff must consider in each individual case whether it is necessary, for the immediate safety of the prisoners, to remove shoelaces and other personal items. These decisions depend on the prisoner, his history, his pattern and method of self-harm along with the level of risk at that point.' I think this is entirely right. However, as already mentioned, staff who were aware of the marks around his neck do not appear to have fully explored their cause and instead accepted his explanation as plausible.

68. The man's family also questioned where he acquired the grease that he put on the cell floor. The investigation team found that trays of individual portions of margarine are sent to the wings three times a week from the kitchen, and prisoners are allowed to have one or two portions each from the delivery. Prisoners cannot buy butter or margarine from the canteen, so the wing delivery is the only source.

69. A further issue raised by the man's family was why he was not on a 'suicide watch' at the time of his death. On the evidence of officers who spoke to the man that day, he was not showing any signs of distress and had not expressed any suicidal intention. On his presentation therefore, there would have been no apparent need for him to have been on an open F2052SH.

70. Prison Service Order (PSO) 2710 details actions staff should take on discovering an apparent death. The Order states that staff should support the prisoner, cut the ligature and place the prisoner onto a flat solid surface before checking for signs of life and attempting resuscitation. Although having no bearing on the ultimate outcome, the first two officers in the man's cell did not support his body or cut the ligature. Other staff arrived shortly after and immediately did so and placed him on the bed.

The Governor should remind staff of the actions they should take on discovering an apparent death.

71. There are no incident reports or statements from the second unlocking officer, from the officer who was also a samaritan or the nurse who attended the scene. Onley's emergency orders for dealing with a death in custody and role briefs require the Duty Governor and Orderly Officer (PO) to ensure that all witnesses remain in the vicinity for taking of statements.

The Governor should remind relevant staff of the need to comply with the prison's emergency orders and role briefs for dealing with a death in custody in ensuring that all witnesses remain in the vicinity and complete a statement of events.

72. Both my investigation and the clinical review have identified a lack of support for discipline staff and healthcare staff involved in the tragedy.

The Healthcare Manager and PCT must ensure that healthcare staff involved in such emergencies are offered support, both emotionally and professionally, in the form of a significant event review.

The Governor should ensure that all discipline staff are offered support, both emotionally and professionally in the form of a hot debrief.

73. The clinical review has identified a training need for all healthcare staff. I judge that training for identification of suicide risk would be beneficial for all healthcare staff and training for significant event review analysis would be beneficial for some specifically identified staff.

The Healthcare Manager and PCT should arrange training for all healthcare staff in identification of suicide risk and offer training for significant event review analysis.

74. The man's father was upset that he was not contacted by the prison after his son's death and learnt of what had happened from his daughter. Any parent can understand why the man's father felt angry and upset at not being contacted by the prison at such a difficult time. However, the man was 30 years old and had nominated his partner as his next of kin, and she was therefore contacted by the prison. I do not believe the prison can be criticised for notifying the nominated next of kin. His father visited the prison on finding out about his son's death and I have been pleased to learn that he was contacted by the prison at a later date.

RECOMMENDATIONS:

***OPERATIONAL*:**

I recommend that the Governor should remind staff of the actions they should take on discovering an apparent death.

I recommend that the Governor should remind relevant staff of the need to comply with the prison's emergency orders and role briefs for dealing with a death in custody in ensuring that all witnesses remain in the vicinity and complete a statement of events.

I recommend that the Governor should ensure that all discipline staff are offered support, both emotionally and professionally via a hot debrief

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***HEALTHCARE*:**

I recommend that the Healthcare Manager and PCT must ensure that healthcare staff involved in such emergencies are offered support, both emotionally and professionally in the form of a significant event review.

I recommend that the Healthcare Manager and PCT should arrange training for healthcare staff in identification of suicide risk and offer training for significant event review analysis.