Investigation into the circumstances surrounding the death of a man at HMP Manchester on 8 September 2006

Report by the Prisons and Probation Ombudsman for England and Wales

November 2007

This is the report of an investigation into the death of a man at HMP Manchester on Friday 8 September 2006. The man was found hanging from his cell window in the prison's healthcare centre only five hours after his arrival from court. He was 35 years old.

A post mortem examination was conducted by on 13 September. It concluded that the cause of death was hanging. A toxicological examination was carried out on 15 September 2006. This found that dihydrocodeine was present in the man's blood and that urine screens had identified cocaine and opiate metabolites. (Metabolites are defined as substances formed in, or for, the process of metabolism.)

I commissioned an independent clinical review of the management of the man's healthcare needs while he was in custody at Manchester. This was undertaken by a representative of the Manchester Primary Care Trust.

I should also like to thank the Governor of Manchester and his staff for their help and co-operation during the investigation. I pay particular tribute to the investigation liaison officer whose contribution was invaluable.

It is particularly distressing that the man died within such a short time of his arrival at HMP Manchester. However, the investigation found that he was given appropriate medical care while he was in the prison.

I make six recommendations, including one commending staff and paramedics who, in very harrowing circumstances, persisted in their attempts at resuscitation.

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

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SUMMARY

At 2:45pm on 7 September 2006, the man was arrested in Manchester in connection with an offence he had allegedly committed a month earlier. He was taken to a police station where, later that evening, he was formally charged with theft from a motor vehicle. He was refused bail and detained in police custody until the following morning when he appeared in court. The man was remanded in custody to Manchester prison and was ordered to appear at the same court a week later. He arrived at Manchester at approximately 5:18pm on 8 September. Initially, he appeared to be tired but alert. However, during the reception procedures, he became so drowsy that he could hardly engage with the staff who were interviewing him. He told an officer he wanted to self-harm but changed his mind when he realised that the officer was about to open an ACCT (Assessment, Care in Custody and Teamwork) form that would trigger formal self-harm monitoring procedures. The officer nevertheless decided to refer him back to the nurse who had earlier completed a health screen. She concluded that the man was not suicidal. Formal self-harm monitoring procedures were therefore not invoked. I am satisfied that this decision was justified.

During his health screen, the man admitted he had used drugs. He was seen by a doctor who decided to prescribe DF118 (dihydrocodeine), but he vomited and the medicine was thus rejected. The man was therefore admitted to the healthcare centre for overnight observation. Shortly after he had arrived in the healthcare centre, an officer attempted to interview him as part of his induction programme. However, the man was very drowsy and therefore unresponsive. The officer terminated the interview and, at about 8:20pm, took him to his single cell opposite the nurses' office. When the man was checked by one member of staff at about 9:00pm he said he was alright and wanted to sleep. When he was checked by another member of staff at about 9:15pm, he was asleep.

At approximately 10:00pm, a member of the healthcare staff began his tour around the centre to administer medications. He went to the man's cell first. As he looked through the observation panel in the cell door, he saw the man hanging from his window. There were no signs of life.

Prison staff attempted to revive the man and, at 10.30pm, he was taken by ambulance to the Accident and Emergency Department at a nearby hospital. Further attempts to revive him in the ambulance and in the hospital were unsuccessful. The man was pronounced dead at the hospital at 10:50pm.

The investigation found that the man was afforded prompt and appropriate medical care.

Whilst I conclude that the emergency response when the man was found hanging was satisfactory, I make one recommendation about the maintenance and serviceability of ligature knives, and another about the use of code words to alert staff to an emergency.

I make six recommendations, one of which recognises the actions of staff and paramedics in their persistent, but alas unavailing, efforts to revive the man after he had been found.

INVESTIGATION PROCESS

1. The investigation was opened on 12 September 2006 when my colleague met with the Governor and other senior managers at Manchester. He also met with a representative of the prison's Independent Monitoring Board and a representative of the local branch of the Prison Officers' Association. My investigator briefed them on the nature and scope of the investigation. On the same day, notices were issued to staff and to prisoners inviting anyone who wished to give information or to express their opinions about the man's death to get in touch with my investigator. No-one came forward. Fourteen people were interviewed.

2. I also commissioned an independent clinical review of the management of the man's health needs while he was at Manchester. This was conducted by a representative of Manchester Primary Care Trust.

3. During the course of the investigation, my colleague spoke to the duty solicitor who saw the man while he was in police custody. My colleague also tried to contact the solicitor who represented the man in court, in an attempt to verify what state he was in at the time. Unfortunately, the solicitor was not available.

4. My colleague spoke to members of the Greater Manchester Police about the man's time in police custody. They were good enough to pass him copies of the man's police custody record. I am grateful to the Greater Manchester Police for their help and cooperation.

5. On 2 November 2006, my colleague and one of my Family Liaison Officers visited the man's partner to ascertain if there were any matters she wished the investigation to address. On 13 November, my colleagues met with the man's parents for the same purpose. The concerns expressed during each visit are addressed in this report.

HMP MANCHESTER

6. Manchester Prison, formerly known as Strangeways, is a Victorian local prison within the Prison Service's high security estate, situated not far from the city centre.

7. At the time of the investigation, the prison served Magistrates' and Crown Courts in the Greater Manchester area, and held up to 1,269 male adult prisoners, including a number of category A (high security) prisoners. Its accommodation comprises two Victorian radial buildings containing nine wings or units with a mix of single and double cells, a segregation unit and a healthcare centre.

8. Healthcare at Manchester is provided by the Manchester Primary Care Trust. The healthcare centre provides 24 hour nursing and medical cover and has beds for up to 38 prisoners.

9. Her Majesty's Chief Inspector of Prisons last inspected Manchester in July 2004. In the report of that inspection, the Chief Inspector recorded her view that the prison was a safer place than when she had last visited in November 2001. However, she said there was more work to be done, especially where the Personal Officer Scheme and staff interaction with prisoners were concerned.

10. The annual report by the Independent Monitoring Board (IMB) at Manchester for the period 1 March 2005 to 28 February 2006 commented that the establishment was a well-run high security prison.

11. Neither the IMB report nor the Chief Inspector's report contains any issues or concerns relevant to this investigation.

KEY EVENTS

7 September 2006: arrest and detention in police custody

12. At 2:45pm on 7 September 2006, the man was arrested in Manchester for an offence he was suspected of having committed on 5 August that year. He had already been stopped by the police earlier that day whilst driving a car, but was not apprehended. After having released the man, the police linked him to the earlier offence and arranged for his arrest. He was taken into police custody in north Manchester, arriving at 3:10pm. His detention was authorised because it was considered necessary to obtain evidence by questioning. The man signed a Detained Person's Rights and Consents form. He recorded that he wanted legal advice but did not want anyone informed of his whereabouts. The Greater Manchester Police custody record noted he had a dependency on heroin, but was fit and well with no apparent injuries or ailments. As the man manifested no signs of illness or injuries, the police did not consider it necessary for him to be examined by a doctor.

13. At 4:42pm, the man completed a mandatory drugs test. This showed he had taken opiates and cocaine.

14. At 6:59pm, the man asked to see the Duty Solicitor, who arrived to see him and to be present while the police interviewed him. The solicitor later told my investigator that his client appeared to him to be in reasonable health and certainly not in any condition that required examination by a doctor. The custody record shows that, at 8:42pm, the solicitor advised the police that, although the man was now of no fixed abode, he nevertheless had "no record of failing to appear" and that he would appear in court if bailed. The solicitor had no further dealings with his client.

15. At 10:27pm, the man was formally charged with theft from a motor vehicle. He was refused bail because of the risk that he might re-offend and because he was considered to be of no fixed abode.

16. At 10:31pm, the man was allowed to make a telephone call from the police station to his partner's mobile phone. His partner later told my investigator that she was driving when she received the call. She therefore asked the man to call her back. She said that he sounded put out by her request and that he did not call her again that night.

17. During the night, the man was observed about once every hour. The entries made in his custody record at 11:28pm, at midnight, and again at 1:11am and 2:03am on 8 September include the comment, "all in order". It is not clear whether the man was asleep at these times. However, the entries made later that night show that he was asleep at 3:00am, 3:40am, 4:25am, 5:16am, 6:11am and 7:25am on 8 September.

8 September: appearance at court and remand in custody at Manchester

18. At 8:16am on 8 September, the man accepted a hot drink in the police station, but refused breakfast. At 8:59am, he was released into the custody of staff from Global Solutions Limited (GSL), a private security firm, who escorted him to court.

19. The Prisoner Escort Record (PER) for the journey between the police station and the court drew attention to violence, drugs and alcohol as risk factors, but carried no notation of any risk of self-harm or suicide. The timings recorded by the police for the journey differ slightly from those recorded by GSL. The police record shows that the man arrived at court at 9:12am. The GSL log records that he left the police station at 9:02am and that was handed over to court staff at 9:48am. A Prisoner Custody Officer (PCO) employed by GSL told my investigator she was one of the staff who escorted the man to court. She confirmed that during the journey he told her he was "rattling" (an expression used by drug addicts to describe the effects of withdrawal), and that he felt ill. The PCO therefore provided him with a number of sick bags. She made a record of this on the PER. When she spoke to my investigator, she said she could not remember the man and explained that her memory of events was based only on the record she made at the time. She could not recount any details of his appearance or demeanour.

20. According to the GSL log of events, "all was in order" when the man was placed in a court cell at 9:48am. He was given a drink at 10:13am. His cell was checked again at 10:37am when the log shows that, once again, "all was in order". This remained the case throughout the numerous checks that were made until 3:58pm when the man was taken into court. During the course of the investigation, my investigator attempted many times to contact the man's criminal solicitor to seek her opinion as to his condition whilst in court. However, she was not available.

21. The magistrates remanded the man in custody and ordered him to appear before them a week later. He returned to the court cells at 4:12pm. At 5:13pm, he was taken to Manchester prison by GSL, arriving at the gate at 5:18pm. The GSL log shows that he was "delivered to the Prison Service at 5:50pm". This was the time at which he would have entered the reception building.

Reception at Manchester prison

22. When the man arrived in reception, a member of staff completed page 2 of his core record. The information recorded on this page normally includes such details as the prisoner's address upon reception and the address and telephone number of his next of kin. At interview, the officer explained that a protocol had been established with court staff that normally required them, rather than reception staff at Manchester, to complete these details in each prisoner's record. This had the effect of saving time in reception at Manchester. However, the officer said that, in this man's case, "the notification from the court was that they couldn't gain any information from him and the record came blank". When he began to interview the man, the

officer immediately noticed he was “very sleepy and uncommunicative”. The officer further explained that the man “was nearly falling asleep, was lolling all over the counter and looked as though he was withdrawing from something”. According to the GSL log, the journey from the court to the prison gate took only about five or six minutes, although it appears that the man did not enter the reception building for about another 20 minutes after his arrival at the gate.

23. The officer said that at no stage did he regard the man as depressed or suicidal.

Health screen

24. A first reception health screen was carried out by a Staff Nurse who recorded the man’s date of birth and his home address. She also recorded his admission that this was not his first time in prison. He told her that he had been in Manchester “years ago”. At interview, my investigator told the nurse he had evidence to show that the man had been in Manchester in March 2005. The nurse said she could only vaguely remember him from that period of imprisonment. She said that when she saw the man in reception at the outset of his current period of imprisonment, she noticed he had lost a lot of weight.

25. During his interview with the nurse, the man said he had not seen a doctor in recent months and did not have any outstanding medical appointments. He said he had never seen a psychiatrist and had never received medication for mental illness.

26. The man admitted to the nurse that, although he did not drink alcohol, he had used cocaine, methadone and heroin in the past month and that he was now withdrawing from methadone. He also said he used cannabis. The nurse thought he was showing some symptoms of withdrawal, including yawning, sweating and shaking. The man told her he had been sick during the journey from court to prison. Despite this, he said he had no concerns about his physical health and was not currently taking any medication. The nurse put a line through the box on the health screen proforma relating to his physical appearance to indicate she had no concerns.

27. The nurse took a urine sample from the man. This contained a large amount of protein, raising the possibility that he had an infection or that he had swallowed drugs. Given his admission that he had taken drugs during the previous month, the results of the urine sample and the man’s demeanour in reception, the nurse decided he should be seen by a doctor with a view to admitting him to the healthcare centre.

28. The nurse did not fully record these details on the health screen form. She told my investigator she was concerned that the man should be seen by a doctor at the earliest opportunity. She said that, in normal circumstances, the full reception procedures could take two hours or more. However, she thought the man was in reception for about 90 minutes. She stressed that,

on more than one occasion, she asked him if he was feeling suicidal and that on each occasion he was adamant he was not. The man told her he had a four year old son and that he had "no intention of doing anything". At interview, the nurse said she was confident that there were no grounds for initiating formal self-harm monitoring procedures.

29. The nurse mistakenly ticked a box on the health screen form indicating no immediate action was required. In fact, she had taken immediate action by referring the man to a doctor.

30. The doctor who saw the man said he thought he saw him at about 6:00pm in the clinic room in reception. He confirmed that the nurse was present.

31. The man told the doctor he had been using about 15 bags of heroin a day and had also been taking methadone, although not for some time. The doctor had no knowledge of what, if any, contact the man had with his GP or with community based drugs support agencies. The doctor shared the nurse's concerns that the man's urine sample raised the possibility that he was suffering from a urine infection or kidney problems. The doctor told my investigator the urine sample also showed the man had been taking cocaine and heroin, but not methadone. He said the test results provided an indication of how much DF118 the man needed in order to prevent him from developing withdrawal symptoms. (DF 118, otherwise known as dihydrocodeine, is an opioid analgesic (painkiller) which, although not licensed for opiate detoxification, is sometimes given to prisoners as an interim measure for pain relief.) The doctor explained that, as the man's sample showed he had not been taking methadone recently, it was appropriate to prescribe a lower dose of DF118. He said it was normal practice at Manchester to prescribe 120 milligrams of DF118 twice daily to patients who were "methadone negative but heroin positive".

32. The doctor explained that, on examining the man, he found his blood pressure was normal (136/80), his pulse (at 55 per minute) was a little slower than normal, his eyes and ears were normal, and there was no evidence of fever. The doctor added that the man kept almost retching during the examination. He said he considered that, although the man seemed rather drowsy, he was coherent. The man told the doctor he wanted to go to his cell to sleep.

33. As the man vomited the first (120mg) dose of DF118 about two minutes after he had taken it, the doctor prescribed a second, larger dose of 180mg together with anti-sickness tablets. He said that, as far as he could remember, this dosage was administered there and then. He suggested that the effects of the medication would have been felt after about 30 minutes. He said that withdrawal symptoms, such as nausea and abdominal pain, should be alleviated. The doctor also explained that the man might have experienced an increased level of tiredness or drowsiness. However, he was clear that the medication would not have had any effect on his mood. At interview, the doctor said:

> "When I see prisoners who are presented before me with a positive urine dip for opiates, I explain the system, how it works, how they have DF118 until they're actually seen by the drugs team who will then chat with them and put them onto a proper detox programme where they may be given something like Subutex instead."

34. The doctor confirmed that he saw nothing in the man's demeanour to suggest he was suicidal. He confirmed that he, personally, did not give any instructions for how often the man should be observed in the healthcare centre. At interview, my investigator asked him how often he would have expected the man to be observed. The doctor replied, "Maybe every half an hour or so." The investigation found there are no policies that require doctors to specify the frequency of medical observations.

35. The doctor said the thought occurred to him to send the man to an outside hospital straightaway. However, he decided to admit him to the healthcare centre first so that, if he deteriorated, he could be transferred to hospital at that point. At interview, the doctor said:

> "Because the withdrawal symptoms were just temporary and if he'd managed to keep the higher dose of DF118, then his symptoms would probably improve and so it wouldn't really be necessary to send him out. At the time, I'd also requested some bloods to be taken as well to make sure that there was nothing else causing his nausea."

Cell-sharing risk assessment

36. During the reception procedures, an officer carried out a cell-sharing risk assessment. At section two of the assessment form, which requires staff to describe any observations or concerns about the prisoner being, for example, racist or homophobic, the officer wrote:

> "Depends on the situation he finds himself in. Stated on interview that he wished to self-harm but when it came to filling in the ACCT form, said he did not. No ACCT form opened."

37. The officer repeated this same entry in the section of the man's core prison file in which daily events are recorded. Elsewhere on the cell-sharing risk assessment form, he recorded that the man had never shown any form of anti-social behaviour in prison but was dependent on drugs. The officer noted that the man had not been subject to self-harm monitoring procedures. In answer to the question, "Would you describe yourself as a person who gets angry and frustrated quickly?", the man said, "Yes". In view of this answer, the officer judged there was a medium risk that the man

might harm someone if he shared a cell. The officer decided to allocate him to single accommodation.

38. In answer to the question, "Is there any evidence of the prisoner having a previous F2052SH?" the officer initially ticked the "yes" box but then changed that entry to the "no" box. (The F2052SH is a self-harm monitoring form that preceded the ACCT system.) At interview, the officer said he mistakenly ticked the wrong box. However, he went on to explain that the man told him he wanted to self-harm. The officer said he asked the man if he had any plans as to how he might harm himself. The man told the officer he did not know. The officer judged that this was an appropriate moment to initiate formal self-harm monitoring procedures by opening an ACCT form and told the man just that. The officer said he went to a cupboard to get a blank ACCT document. When he returned, the man said to him, "What have you got one of those things for? I told you I'm not suicidal." The officer said he again discussed with the man whether or not he was suicidal. At the end of his discussion, the officer decided to err on the side of caution by referring the man for a second opinion from the nurse who was also in reception. When the nurse saw him, he told her he was not suicidal. The nurse wrote at section 3 of the cell sharing risk assessment form, "States has never self-harmed and has no intention of doing so." The ACCT form was therefore not opened.

Telephone call to the man's partner

39. At 6:35pm, the man made a telephone call from reception to his partner's mobile phone. No-one replied. However, a recording of the call shows he said:

> "It's me. I'm in Strangeways. I think you're really sly not giving me your address. I'm f***ing dying. See you later. I love you and the kids. Are you ok? Phone you later. Bye."

40. The man's partner later explained to my investigator that he often said he was dying when he had taken drugs. She therefore attached no significance to his utterances on this occasion.

Admission to healthcare centre

41. The nurse told the doctor she thought it best to admit the man to the healthcare centre for overnight observation. The doctor agreed and wrote in the man's medical record:

> "Uses 15 bags of heroin daily. Not had methadone for 1/52. Has just vomited DF 118 120mg. Stat dose of DF118 180mg. Admit to Health Care."

42. The man was placed in cell Y-06, immediately opposite the nurses' office on the upper floor of the healthcare centre. He arrived at about 8:00pm.

24 hour nursing care plan

43. A staff nurse who was nearing the end of her day long shift in the healthcare centre, saw the man at 8:10pm in order to complete a 24 hour nursing care plan for him on the instructions of the inpatient manager on duty at the time. The nurse said she did not have sight of the health screen form completed earlier by her colleague. She first saw the man sitting in an armchair on the inpatient landing and noticed he was falling asleep. She took him into a room to begin the interview, but found he was so exhausted he could not answer any of her questions. The nurse made a comment to this effect in the care plan. She also noted he had been placed on medical observations but did not specify what these were. She told my investigator she only noted this because she had been told by the inpatient manager of the reasons for the man's admission to the healthcare centre. She recorded that he was not currently subject to self-harm monitoring procedures.

44. Because of the man's inability to stay awake, the nurse felt unable to answer the full range of questions prompted by the proforma. The man asked her if he could go to his cell, but she told him he would have to wait to be seen by an officer for induction purposes. She told him to wait outside the office and then went off duty.

45. The man was next seen by an officer as part of the first-night induction procedure. At interview, the officer said he saw the man sitting on a chair outside the office, curled up under his coat. He seemed to be asleep. The officer called out his name and the man woke up. The officer took the man into the office and prepared the relevant paperwork so that he could begin the induction interview. As he began putting questions to the man, the officer noticed he was "nodding off". The officer therefore thought it better to conclude the interview there and then. He decided to continue the following morning. The officer thought he was with the man for about five minutes. When asked what he thought was wrong with him, the officer said he was exceptionally sleepy. The officer could not say whether the man's eyes were bloodshot, or whether he was clammy or sweating. The officer did not think the man was feigning his condition. However, he said that at no stage did he give any impression of being suicidal. After the officer had terminated the interview, he took the man to his cell opposite the office, opened the door and let him in. The officer said that the man went straight to his bed. The officer then went off duty. He said his shift ended at about 8:30pm.

Discovery of the man hanging

46. The night shift in the healthcare centre started at 8:45pm. Those on duty in the centre that night included a staff nurse, an officer and a healthcare officer.

47. The staff nurse arrived in the healthcare centre at 8:00pm. He told my investigator that, as he entered the main office in the healthcare centre, he

noticed an officer interviewing a prisoner who, at the time, he did not recognise, but whom he later knew to be the man. The staff nurse saw the man sitting in front of the desk in the office and noticed "seemed quite drowsy". He heard the officer tell him he was not making much sense and witnessed the officer terminating the interview. The staff nurse then went to the association room in the healthcare to have a cup of coffee and a cigarette. Afterwards, at about 8:20pm, he saw the officer take the man back to his cell which was immediately opposite the office. At interview, the staff nurse stressed that he noticed nothing in the man's demeanour to suggest he was depressed or suicidal.

48. Shortly afterwards, there was a brief handover meeting between the night staff and the inpatient manager who had been on duty in the healthcare centre since 12:30pm that day and whose shift was about to end. At interview the manager said the nurse in reception telephoned to let him know the man was to be admitted to the healthcare centre for observation because he had "a drug problem" and because it was not safe to send him to a wing. At the handover meeting, the manager told the night staff the man had been given DF118. He said that he had been sick after his first dose of the drug. The doctor was therefore concerned to keep him under observation and to allow him an opportunity to resume his medication once his nausea had passed. Both the staff nurse and the healthcare officer told my investigator no clear instructions were given during the handover meeting as to what observations were to be made of the man during the night. The manager said that, just before he went off duty at about 9:00pm, he went to the man's cell door and asked him if he was alright. The manager said that he replied, "Ok, I want to sleep."

49. The staff nurse said that after the handover meeting, probably around 9:00pm, he went to the treatment room to check that the recordable drugs to be given to inpatients that night were ready on the drug trolley.

50. At about 9:15pm, the healthcare officer checked on the man. She looked at him through the observation panel in the cell door and saw he was asleep in his bed. The night-light in his cell was on. The healthcare officer said she saw no signs of vomit or anything else untoward.

51. At about 10:00pm, the staff nurse took the drug trolley to the inpatient landing. The first cell he approached was Y-06, occupied by the man. The staff nurse opened the observation hatch in the cell door and noticed the cell light was off. He therefore shone his torch into the cell. As he did so, he saw the man hanging from the cell window by a ligature made from his bed sheets. The staff nurse told my investigator nothing had been said to him about the man being at risk of suicide. He was therefore not prepared for what he saw. He pushed the trolley out of the way and locked it. At the same time, he shouted to his colleagues in the office opposite the man's cell. The officer and the healthcare officer ran to the cell together. Both told my investigator they had some difficulty in opening their emergency key pack which included a cell key and a pair of scissors provided to enable staff to cut through ligatures. The officer was the first to succeed in opening his

pack. Although the officer could not remember how long it took him to do so, the healthcare officer thought it might have taken 50 seconds or more. The officer used his key to unlock the cell door. Both he and the healthcare officer then entered the cell. As they did so, the healthcare officer sent an urgent message on her radio to the Control Room staff, saying, "Urgent message, Oscar 1, Oscar 2, assistance required, we have someone hanging." Meanwhile, the staff nurse went to collect a defibrillator and the emergency bag containing resuscitation equipment from the landing below. My investigator was told that, although this did not take long to achieve, the journey nevertheless entailed unlocking and locking a number of security gates.

52. By the time the staff nurse returned to the cell approximately two minutes later, the officer and the healthcare officer had between them removed the ligature from the window and from the man's neck. The healthcare officer told my investigator the scissors she had used to cut the ligature were not very sharp because no one ever sharpened them. With the assistance of a colleague, they had also removed the man to the landing outside the cell where there was more space available. The healthcare officer had checked the man's carotid pulse, his pupils and his skin colour for signs of life and had found none. The healthcare officer had found that the man's body was still warm with no signs of rigor mortis.

53. Neither member of staff could remember who called for an ambulance but the log of events compiled by the prison shows one was called at 10:04pm.

54. Upon his return, the staff nurse inserted an airway while the healthcare officer applied a defibrillator. The machine advised her not to shock. Both members of staff then applied cardiopulmonary resuscitation (CPR) techniques until the ambulance crew arrived at the cell at 10:16pm. However, during that period, the healthcare officer said she heard one of the man's ribs crack. This distressed her and so she asked a colleagueto take over compressions from her. At approximately 10:30pm, the man was taken by ambulance to a nearby hospital, accompanied by another member of staff. On the way to the hospital, and in the Accident and Emergency Department, further attempts were made to revive the man but without success. He was pronounced dead at the hospital at 10:50pm.

55. The man's prison record shows his partner was registered as his next of kin. However, the chaplain told my investigator that, when the police were asked to inform the man's partner of his death, they could not find the address listed in his prison record. (In fact, the address was later found to be in the prison record.) The chaplain said that, as the police knew of his family, they chose to inform them of his death, rather than his partner. They did so at the family home later that evening.

9 September

56. The following day, the chaplain telephoned the man's parents but they were too upset to talk to him. However, they agreed to make contact the next

day. Most unfortunately, the man's partner was told of his death at work by a third party. The chaplain spoke to her over the phone and agreed to accompany her to the mortuary later that day. When they arrived, they were told that the visit had been postponed until 1.00pm the next day.

10 September

57. On 10 September, the chaplain met both the man's partner and his parents at the mortuary. After they had identified the man's body and paid their respects, the chaplain held a short service and a formal blessing. The man's parents then asked to be left to make the arrangements for their son's funeral without any assistance from the prison. They confirmed they were content for representatives of the prison to attend the funeral, and asked that they should be allowed to send flowers to be placed where their son had died.

58. The Governor offered to assist with the cost of the funeral, but this offer was declined by the family.

ISSUES

59. Here I examine :

- Why the man arrived at Manchester in a drowsy condition.
- Whether his health needs were properly met.
- Whether his risk of suicide was properly assessed and whether appropriate decisions were made about the management of his risk.
- Whether the response to the discovery of the man hanging was appropriate and effective.
- Whether the man's family were offered appropriate support after his death.

Why did the man arrive at Manchester in a drowsy condition?

60. When he arrived at Manchester prison shortly after 5:00pm on 9 September, the man was so drowsy he was hardly able to stand up. There are several possible explanations for his being in that condition. He may not have slept properly whilst in police custody; he may have been under the influence of drugs; he may have been withdrawing from drugs; or he may have been suffering from another form of illness. As his subsequent treatment at Manchester pivoted around the condition he was in when he arrived, my investigator considered it was essential to attempt to discover what had caused it.

61. The investigation found that, when the man left his partner's house at about 2:00pm on 8 September, he was perfectly alright according to her, although apparently on his way "to get a fix". Shortly afterwards, whilst driving a car, he was stopped by the police but immediately released. At 2:45pm, he was arrested and taken to a police station. There is no evidence to suggest he was drowsy, ill or under the influence of drugs at that time. His police custody record shows he was considered not to be suffering from any injury or ailment when he was arrested or during the period of his detention. The police judged it was not necessary for him to be seen by a doctor. However, the man admitted to the police he was a heroin user. At 4:42pm, he was given a mandatory drugs test and tested positive for opiates and cocaine. However, the custody record contains no notation of any manifestation of withdrawal symptoms or of any behaviour suggestive of the current use of drugs. The duty solicitor who saw him during the evening of 8 September told my investigator he saw nothing to suggest he was ill or in need of attention by a doctor. The record shows that the man slept reasonably well during the night of 8/9 September. If he was tired on the morning of 9 September when he appeared in court, there is no evidence to suggest his level of tiredness was such that he could not stand up or keep awake at that stage.

62. The only time the man showed that something was wrong with him was when he was on his way to court from the police station during the morning of 8 September. During the journey, he told a prisoner custody officer on the vehicle he was "rattling" - i.e. withdrawing from drugs. The PCO gave him some sick bags. As noted earlier, my investigator attempted several

times to contact the man's legal representative in court, to seek her opinion of his condition whilst there. However, my investigator's efforts were unsuccessful.

63. By the time the man arrived at Manchester after the short journey from the court during the early evening of 8 September, he was too drowsy to engage fully with the staff who needed to interview or examine him. He vomited his detoxification medication and was admitted straightaway to the prison's healthcare centre.

64. There is no concrete evidence to show why the man was in such a drowsy condition when he arrived at Manchester. However, it is a fact that he tested positive after a mandatory drugs test whilst in police custody. It is also a fact that the post mortem examination found elements of cocaine in his body.

65. I believe the man's drowsiness at Manchester was the result either of his having taken drugs between leaving his partner's house on 7 September and the time of his arrest a little later that day, or of withdrawing from drugs he had taken at an earlier point. In my view, the latter explanation is more plausible.

Were the man's health needs properly met?

Reception health screen

66. During the reception procedures carried out upon his arrival at Manchester, the man was seen by a nurse who conducted a health screen. The nurse took his history and he declared no health problems or recent contact with doctors. He said he had never seen a psychiatrist. However, he disclosed he had used heroin, cocaine, methadone and cannabis in the previous month. The nurse who saw him in reception took a urine sample which showed he had taken cocaine and heroin. The nurse noticed that, whereas the man was initially tired but alert, his drowsiness increased during the course of her consultation.

67. The nurse did not fully record all the details gleaned during the health screen. The clinical reviewer takes the view that, although there are gaps in the information asked for in the form used, and inconsistencies in the style of completion, these had no detrimental effect on the screening process. The reviewer is satisfied that the information the nurse gained was relevant and sufficiently comprehensive to ensure that she was able to act in the man's interest and oversee his passage through the reception process.

68. The author makes no formal recommendation about record keeping and draws attention to her awareness that Manchester was going to great lengths to improve its standards of documentation and record keeping. I agree with her conclusions.

69. The doctor who saw the man in reception was of the opinion that the urine sample showed a significant presence of protein, indicating that he might be suffering from an infection. The doctor took his blood pressure and pulse. Both were within normal limits. The doctor also examined his eyes and ears to check for recent drug use, and for neurological or sensory problems. Nothing abnormal was detected.

Management of drug withdrawal

70. In reception, the nurse and the doctor thought the man was showing signs of withdrawing from drugs. The doctor prescribed DF118, the first dose of which was administered by the nurse in the doctor's presence. The man immediately vomited, thereby expelling the DF118. The doctor then prescribed an anti-emetic drug which was administered straightaway.

71. The doctor thought that the man's symptoms were likely to be of short duration and that it was reasonable to prescribe a further dose of DF118 once his vomiting had settled. After discussing the man's situation with the nurse, he decided to admit him to the healthcare centre for overnight observation. The doctor took the view that, if the man's condition deteriorated, he could be transferred to an outside hospital.

72. The author of the clinical review concludes as follows:

> "It is evident from the actions of both the doctor and the nurse that there was close co-operation and discussion on the man's care. The response by the doctor to his drug problem was appropriate and the treatment within the agreed protocol. The physical observations taken were standard baseline recordings, and there was nothing in them to suggest the man had any significant difficulties over and above "withdrawing " Unusually, he spent longer time in the company of both the doctor and the nurse which gave them both ample opportunities to observe him. Both acted to expedite his admission, a decision that was made for clear reasons i.e. to give a second dose of DF118 within the agreed protocol."

Admission to the healthcare centre

73. Not long after the man's admission to the healthcare centre, there was a brief handover meeting between the night staff and the inpatient manager. At interview, the manager said that the nurse telephoned him from reception to let him know the man was to be admitted to the healthcare centre for observation because he had "a drug problem" and because it was not safe to send him to a wing. At the handover meeting, the manager told the night staff the man had been given DF118. He said the man had been sick after his first dose of the drug, and the doctor was therefore concerned to keep him under observation and allow him an opportunity to resume his medication once his nausea had passed.

Level of observations in the healthcare centre

74. At interview, both the staff nurse and the healthcare officer said no clear instructions were given during the handover meeting as to what observations were to be made of the man during the night. However, the author of the clinical review concludes that, given the absence of any significant signs or symptoms other than tiredness and vomiting, there was no requirement to set out specific instructions for the frequency of observations.

24 hour care plan

75. At about 8:10pm, a 24 hour care plan for the man was made out by a staff nurse. In her clinical review, the author comments that the purpose of the care plan is to identify any immediate problems and to institute short term actions. The staff nurse did not have sight of the health screen form that had been completed in reception. She had difficulty getting the man to answer her questions because he was extremely tired.

76. The author of the clinical review concludes that, although the care plan was weak, for the reasons described above it was based on a clear understanding of the basis for the man's admission to the healthcare centre. The author also comments that a joint decision was made to locate the man in a cell immediately opposite the nurses' office.

Health needs as a whole

77. The man's immediate health needs were properly screened in reception. According to the author of the clinical review, his drug withdrawal was properly diagnosed and treated. The decision to admit him to the healthcare centre for overnight observation was appropriate. Although no firm instructions were given as to the frequency at which he needed to be observed, the man was observed at about 9:00pm by the inpatient manager just before he went off duty, and at about 9:15pm by a healthcare officer. The inpatient manager said he asked the man if he was alright and he replied that he was and that he wanted to sleep. The healthcare officer said that she looked into his cell and saw him asleep in his bed.

78. In the recent past, many prisoners who were detoxifying were treated with dihydrocodeine. As I noted in earlier in this report, dihydrocodeine is not actually licenced for opiate detoxification, and prisons are a lot safer now that more appropriate detoxification arrangements are in place. However, in this case, it was being used as a temporary measure as a painkiller. For that reason, and in light of the findings of the clinical review, I conclude that the man's healthcare needs were satisfactorily met.

Was the man's risk of suicide properly assessed and were appropriate decisions made about the management of his risk?

79. The investigation found no documentary evidence to show the man's medical or psychiatric history prior to his arrival at Manchester on the evening of 8 September 2006. His partner told my investigator that he had a long history of drug abuse and that, although he therefore ran a risk of overdose, at no stage did she consider him to be suicidal. There were no indications of any risk of suicide during the time he spent in police custody.

80. However, during the reception procedures, the man told an officer he wanted to self-harm after already having told a nurse he did not feel suicidal. In response, the officer made ready to initiate formal self-harm monitoring procedures by fetching an ACCT form from a cupboard. Upon seeing the officer do so, the man told him he was not suicidal. The officer therefore did not open the form. However, as a precaution, he asked the reception nurse to asses him again. On doing so, she concluded that he was not suicidal. Consequently, self-harm monitoring procedures were not initiated.

81. The reception officer concerned reacted appropriately by preparing to open an ACCT form when the man said he wanted to self-harm. The officer also reacted properly by taking the precaution of asking a nurse to re-assess his risk of suicide after the man had apparently changed his mind. It is clear that he told the nurse during that reassessment he did not feel suicidal. I take the view that, in the circumstances, the reception staff were justified in not opening an ACCT form.

Was the response to the discovery of the man hanging appropriate and effective?

82. When the staff nurse discovered the man hanging in his cell, he raised the alarm by shouting towards his colleagues in an office a matter of feet away from the man's cell. Their response was immediate, and they were at the cell door within a few seconds.

83. One of the members of staff who responded reported that he had difficulty opening the sealed pouch on his belt containing emergency keys. It was estimated that it might have taken him about 50 seconds to withdraw his keys. My investigator examined a sealed pouch during the course of the investigation and concluded there was no significant design fault. It was likely that the difficulty in opening the key pouch had more to do with the trauma experienced on finding the man hanging than with the design of the pouch. If this was the case, it was perfectly understandable. I consider that there was no undue delay in entering the man's cell. I make no formal recommendation on this matter.

84. The healthcare officer who cut away the ligature told my investigator the anti-ligature scissors she used were not very sharp "because no-one ever sharpened them". However, there is no evidence that the condition of the scissors used significantly impeded the removal of the ligature.

In keeping with the provisions of Prison Service Instruction 32/2006, the Governor should check that proper arrangements are in place to ensure that items of equipment issued to staff for the purpose of removing ligatures are properly maintained and fully serviceable.

85. When the man was discovered hanging, the healthcare officer sent the following urgent message to the Control Room:

> "Urgent message, Oscar 1, Oscar 2, assistance required, we have someone hanging."

86. The message made perfectly clear the circumstances of what had been discovered, and, therefore, what type of assistance was required. However, it also raised the possibility of alarming other prisoners. My investigator was given to understand that the use of code words to describe various categories of emergency had been discussed at Manchester, but that no clear policy for their use was in place.

The Governor should consider introducing code words for use in life threatening situations, such as Code Blue for hangings and Code Red for severe blood loss, which staff can use over the radio to call up appropriate medical and other assistance without causing undue alarm.

87. These matters aside, I consider that the response to the discovery of the man hanging was entirely proper. It is clear the staff involved were deeply affected by the events. They nevertheless persisted in their attempts to save the man both in the prison and in the ambulance when he was transferred to hospital.

The staff at Manchester and the paramedic crew who tried to save the man should be commended for their conduct in such harrowing circumstances.

Was the man's family offered appropriate support after his death?

Breaking the news of the man's death to his parents and next of kin

88. The man's partner told my investigator that, rather than learning of his death from the prison or the police, she was told by a third party. She asked for an explanation about why this happened.

89. At interview, the prison's chaplain said that the address of the man's partner recorded in his file was incorrect. As a result, prison staff had difficulty discovering where she lived and asked the police to inform her. In fact, the man's partner's details were correctly recorded in his file. The police took it upon themselves to inform his parents rather than his partner.

90. I am concerned about the manner in which the man's partner learned of his death. It is most unfortunate that she was told by a third party rather than by someone in authority. As the listed next of kin, the man's partner should

have been attributed the same courtesies afforded to his blood relatives. This is one of many reasons why I believe a prison should take charge of its own family liaison responsibilities rather than relying on the police.

The Governor should ensure that his contingency plans for managing a death in custody legislate for the proper communication of a prisoner's death to the listed next of kin, whoever that might be, as well as to other relatives.

91. My family liaison officer was told by the man's sister that her family were given conflicting information about the method he used to kill himself. She said she was told by one person that he had used torn bedsheets and by another that he had used his shoelaces. This is another reason why, whenever practicable, the prison itself should inform a family of death in custody.

The Governor should ensure that the method adopted for communicating the news of a prisoner's death to his family is sufficiently structured to minimise the risk of imparting inconsistent or inaccurate information.

Ongoing support for family and partner

92. On 10 September, the chaplain met the man's parents and partner at the mortuary. It is to the chaplain's credit that he made these arrangements but the man's family have expressed concern about a lack of contact from anyone in the prison thereafter. Although the chaplain has produced clear evidence that telephone conversations took place with the man's parents on 14, 18 and 25 September during which funeral arrangements and other matters were discussed, it appears that nobody visited them at their home. This was a matter of particular concern to the man's mother who suffered a heart attack in the aftermath of her son's death. Whilst I make no formal recommendation, I wonder whether more consideration could have been given to visiting the family.

Handling the man's personal effects

93. My family liaison officer was also told the man's belongings were returned to his parents without any reference to his partner. This added to the distress his partner felt in the aftermath of his death.

The Governor should ensure that proper consultation takes place with the next of kin with regard to the handling of the prisoner's personal effects.

LIST OF RECOMMENDATIONS

Handling emergencies:

1. In keeping with the provisions of Prison Service Instruction 32/2006, the Governor should check that proper arrangements are in place to ensure that items of equipment issued to staff for the purpose of removing ligatures are properly maintained and fully serviceable.

2. The Governor should consider introducing code words for use in life threatening situations, such as Code Blue for hangings and Code Red for severe blood loss, which staff can use over the radio to call up appropriate medical and other assistance without causing undue alarm.

3. The staff at Manchester and the paramedic crew who tried to save the man should be commended for their conduct in such harrowing circumstances.

Information to next of kin:

4. The Governor should ensure that his contingency plans for managing a death in custody legislate for the proper communication of a prisoner's death to the listed next of kin, whoever that might be, as well as to other relatives.

5. The Governor should ensure that the method adopted for communicating the news of a prisoner's death to his family is sufficiently structured to minimise the risk of imparting inconsistent or inaccurate information.

Handling personal effects

6. The Governor should ensure that proper consultation takes place with the next of kin with regard to the handling of the prisoner's personal effects.