

**INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING
THE DEATH OF A MAN AT HMP KINGSTON
IN SEPTEMBER 2006**

**Report by the Prisons and Probation Ombudsman for England
and Wales**

July 2007

This is the report of an investigation into the death of a man in September 2006. He was a life sentence prisoner at HMP Kingston. He was found dead in his single cell with two plastic bags taped over his head. He was aged 64.

I offer my sincere condolences to his family and friends.

The investigation was led by one of my colleagues. My thanks also go to a number of clinicians at Portsmouth City Primary Care Trust, particularly to the chair of the review panel that assessed the clinical care given to the man while in custody.

I am grateful too for the assistance my colleagues received from the staff and management of Kingston prison. I also acknowledge the help of Hampshire Police who carried out their own enquiry into the man's death and readily shared their information with me.

The greatest number of self-inflicted deaths in prison occur in local prisons and amongst those recently received into custody. This man was representative of a different group of prisoners: those long into their sentences who seem to feel that they have no prospect for release. I have little doubt that his anticipation of a 'knock back' from the Parole Board was a major factor in his apparent decision to take his own life.

During his years in custody, the man had been subject to formal suicide and self-harm monitoring and support on six occasions. However, in the immediate period prior to his death he was seen to be in a very good mood. Although it is counter-intuitive, as I report later in this document an improvement in mood immediately before a self-inflicted death has been recognised in the literature on suicide, and has been found in a number of my investigations.

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Prisons and Probation Ombudsman

July 2007

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SUMMARY

This is the report of an investigation into the death of a prisoner at HMP Kingston. On the morning of 25 September 2006, he was found in his cell at HMP Kingston with two plastic bags taped over his head. Staff decided that resuscitation was futile as there were no signs of life. This was confirmed by the doctor who said that rigor mortis had started to set in.

The post mortem concluded that the cause of death was asphyxiation.

The man was a life sentence prisoner and had been in prison since 1988. He had been resident at Kingston since September 2003. By September 2004, he had progressed through the lifer system to a point where he was granted permission to transfer to a prison with open conditions. However, on one occasion, he was believed to be under the influence of alcohol or drugs after an escorted visit which placed his progression in jeopardy.

Staff opened an ACCT form on 14 June 2006. (This is a document designed to coordinate the care and observation of a prisoner who is vulnerable to suicide or self-harm.) It was closed on 26 July when staff were content that he was no longer vulnerable to suicide or self-harm.

On 13 September 2006, his case was reviewed by the Parole Board. The occasion when he was thought to have misused drugs or alcohol had affected his status and the Board decided that he should remain in closed conditions. He had not formally been notified, but he told his personal officer that he knew the outcome.

Staff and prisoners remember him as humorous, likeable and frail man. However, he did have a reputation for being grumpy and for complaining.

My report includes a total of nine recommendations. A further 14 have been made by the clinical review panel.

THE INVESTIGATION PROCESS

1. The investigation was conducted by one of my colleagues. He visited HMP Kingston and saw key locations including the healthcare centre and the wing where the man was located.
2. The investigator issued notices to staff and prisoners, inviting anyone with information relating to the man's death to make themselves known. He spoke to a number of prisoners who responded to the notice.
3. The investigator also spoke to the Chair of the Independent Monitoring Board (IMB), a representative of the local branch of the Prison Officers' Association (POA), one of the prison chaplains, and various other members of staff including the Safer Custody Manager. He formally interviewed a number of prison staff and healthcare professionals involved in the events surrounding the man's death. In addition, the investigator spoke informally to other staff and to prisoners.
4. The prison gave the investigator full access to all the documentation surrounding the man's time in prison. The police also provided copies of the documents and statements in their possession.
5. One of my family liaison officers spoke on the telephone to the man's brother. He gave a little background information, but had no specific issues to raise. Indeed, the man's death had resurrected such unhappy memories that his brother did not feel able to be involved in the investigation. However, he would welcome a copy of my investigation report.
6. The review panel for Portsmouth City Primary Care Trust (PCT) undertook a clinical review of the man's care while in prison.
7. Following the publication of the draft report the Prison Service Area office commissioned its own investigation, and the report has been amended in the light of their feedback.

HMP KINGSTON

8. HM Prison Kingston was built in 1877 to a radial design. It currently serves as a specialist prison for life sentence prisoners. One wing is for prisoners who have reached category C. The prison holds a maximum of 192 prisoners. On the day of the man's death, the prison was full.
9. The overall establishment rating is four (four being the highest and one the lowest). This rating is established from a number of factors, including performance against area targets, Prison Service National Standards and independent inspection by Her Majesty's Chief Inspector of Prisons (HMCIP).
10. In relation to Prison Service National Standards, the establishment attained a rating of 'Good' for non-security and security, which were marked as 88% and 87% respectively during the most recent audit in November 2005. Suicide awareness and self-harm procedures were also rated as 'Good', achieving a mark of 84% compliant with the relevant standard.
11. Following an inspection in December 2005, HM Chief Inspector, reported that Kingston had improved considerably and had a senior management team that was clear about its role and purpose. Relationships between prisoners and staff were relaxed and friendly. However, the Chief Inspector said there was a lack of positive engagement, such as personal officer work, and of interaction with prisoners while out of their cells. For example, bullying for medication was an acknowledged problem, but the queue for medications was virtually unsupervised during HMCIP's inspection.
12. The Chief Inspector noted that managers had tackled a significant problem with illegal drugs and were about to cut down on the over-prescribing which had led to trading in opiate-based medications. Healthcare had suffered from slow engagement by Portsmouth PCT, and the Chief Inspector said that the prison required both stronger clinical leadership and the development of chronic disease management clinics and mental health work to support the needs of its ageing and long-stay population.
13. My investigator found that some progress has been made by the prison and the PCT in response to the findings and recommendations of the Chief Inspector.
14. In common with many prisons, Kingston issues prisoners with a pre-packed breakfast meal. This is collected with the previous evening meal and is intended to be eaten by the prisoner in his cell before the cells are unlocked in the morning. The breakfast is packed in a clear and un-perforated plastic bag, which typically contains cereal, milk, bread roll, butter, preserves, sugar and tea/coffee.

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Life Sentence Prisoners

15. Following sentencing, life sentence prisoners are advised of the minimum period that they must serve before they can be considered for release on life

licence. This is often referred to as the tariff. No life sentence prisoner can expect to be released before they have served the minimum sentence period.

16. Life sentence prisoners are initially moved to a 'First Stage' centre. During this time the prisoner's Life Sentence Plan (LSP) is developed. The LSP is a tool that assesses the risk factors that contributed to crime. The LSP is written and targets are set, aimed at reducing the risk of re-offending.
17. Once the risk factors are identified and the appropriate courses are agreed, the prisoner can then move to a 'Second Stage' prison that offers the appropriate courses and environment for the individual to progress through their plan. Kingston is one such 'Second Stage' prison.
18. Regular risk assessments are carried out in order to assess a lifer's progress in reducing the likelihood of re-offending. A Parole Board panel reviews whether prisoners are ready to progress to a lower category prison, including open conditions (Third Stage), or release.
19. Once released, the lifer is supervised by the Probation Service. Although the supervisory element of the licence may eventually be cancelled, they remain liable to recall to prison for the rest of their natural life.

Suicide and Self Harm Monitoring Procedures

20. Prison Service suicide and self-harm procedures are set out in Prison Service Order (PSO) 2700. The Assessment, Care in Custody and Teamwork (ACCT) system is used when a prisoner is identified as being vulnerable to self-harm or suicide. (ACCT replaced the former F2052SH process, and is a significant advance upon it.) The aim of the system is to enable staff from all disciplines to work together with the individual, creating a safe and caring environment, where distress is minimised and those prisoners who are distressed feel they are able to ask for help. It should identify individual need and offer individualised care and support before, during and after crisis.
21. Staff are taught to recognise the signals that a prisoner who is in distress may display. When a member of staff is concerned they may raise an ACCT document which triggers a care planning process. The prisoner is encouraged to talk about their problems, which staff attempt to reduce using a care plan combined with extra support and possibly increased observation.
22. The PSO says at annex B that, when an ACCT is opened, the manager of the unit where the prisoner resides must:
 - decide, in consultation with healthcare staff, whether to manage the prisoner on the residential unit or refer initially to the Healthcare Centre (HCC), and document reasons;
 - ensure that, where available, prisoners on an open ACCT have been offered the opportunity to talk to a Listener and/or Samaritan; [Listeners are

prisoners trained by the Samaritans, and provide a confidential listening service.]

- ensure a case review is held within 24 hours, and document a summary of the review and agreed care plan.

23. A care plan must be drawn up and agreed by all involved, including the prisoner. Multi-disciplinary case reviews must be held as necessary, including in the event of a further act of self-harm. The ACCT should be closed following a case review when the prisoner appears to be coping satisfactorily. The case review will agree after-care or follow-up requirements.

Healthcare Centre

24. Portsmouth City Primary Care Trust took over the commissioning of healthcare at Kingston in April 2005. Under this arrangement, Kingston managed the delivery of healthcare, having a non clinical manager in place, supported by a lead nurse. The PCT employed a nurse and a healthcare assistant, but had no managerial responsibilities for Kingston. In May 2006, the PCT decided to take on the full provision of healthcare, with effect from 1 October.

25. Provision includes 24 hour doctor on call cover, but no in-patient facility. Prisoners requiring 24 hour nursing cover are either transferred to local hospitals or another prison with such provision. Additional services include a psychiatrist, visiting dentist, pharmacy, GP surgeries and nurse triage. Two doctors from a local practice attend Kingston for two hour sessions on Monday, Wednesday and Friday.

26. If emergency medical assistance is required, then the member of staff detailed radio call-sign 'hotel' responds, taking the emergency equipment bag with them. They assess the situation and commence any emergency treatment, before deciding on the next course of action. The person detailed as 'hotel' is available throughout the day and is contactable from the communications room via the UHF radio. On 25 September 2006, this was the duty nurse.

27. Since the death of this man, the PCT are making number of key changes. From 1 October, the PCT provider arm has taken on full management of the service and a clinical nurse manager has been employed. Healthcare service times have been extended and the issuing of some of the opiate based medication is now supervised. There is improved communication between the healthcare team and the rest of the prison. The Clinical Governance and Medicines Management groups are well established. Additionally, a review of the GP cover and of the mental health services provision is planned.

28. The above developments are part of ongoing work to support the prison healthcare action plan. These are monitored as part of the quarterly prison healthcare service reviews within the PCT commissioning process.

Psychiatric Services

29. Psychiatric services include a community psychiatric nurse (CPN). She is commissioned by the PCT as a Mental Health Gateway Worker, delivering mental health support to prisoners. She works at the prison from Tuesday to Friday and has a typical caseload of around 15 prisoners. She attends the Suicide Prevention Team meetings and is a member of the local safer custody group.
30. The CPN is clinically supported by a general consultant psychiatrist who holds a clinic at the prison every week. There had been difficulties obtaining regular psychiatric services for the weekly morning clinics. There was no provision between March and August 2006 inclusive, due to an unfilled position. However, a consultant psychiatrist is now in post.

Drug Strategy

31. There is a multi-disciplinary approach to tackling the problem of drug use in the prison. Detection involves drug dog searches, cell and area searches and Mandatory Drug Testing (MDT). Throughcare includes one-to-one working with a drug worker and support from the Counselling, Assessment, Referral, Advice and Throughcare (CARATs) team. The prison also offers voluntary drug testing to monitor progress, group-work, a helpline to Narcotics Anonymous, auricular acupuncture, and other medical support. All grades of staff at Kingston are trained in drug awareness.
32. Prisoners are identified from their reports and interviews, as well as positive MDT results. There are arrangements with the Healthcare Centre at HMP Winchester for the transfer of prisoners who require detoxification.

Roll Checks

33. The following instructions are extracted from the security section of the Prison Officer training manual, with regard to the roll checks:
 - Count the prisoners in their cells and get a response.
 - This means that you physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement.
 - If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is not ill or dead.
34. Kingston's Local Security Strategy 2.06 for Routine Roll Checks came into effect on 19 March 2004. It requires that roll checks are conducted at least four times every 24 hours when night staff handover in the morning, prisoners are locked up at lunchtime and teatime and the end of the day at 8.00pm. Night

staff conduct additional roll checks when they come on duty, at 6.30am the next morning and at any other time as instructed by the manager in charge during the night. Every roll check must result in a response from the prisoner, and if no response is forthcoming, staff are instructed to seek assistance.

Unlocking of Prisoners

35. The following instructions with regard to the unlocking of prisoners are also extracted from the security section of the Prison Officer training manual:

“The locking up and unlocking of prisoners is a fundamental task of a prison officer:

- Stand back away from the door when opening observation port cover and check that the window insert is intact and not broken.
- Place palm of hand, with fingers spread over the observation port.
- Withdraw the additional security bolts on the cell door if there are any, checking that the bolts and retaining brackets are in good condition.
- Place the hand on the door handle and take a firm hold.
- With the other hand insert the key into the lock and rotate it to the stop position, in an anti-clockwise direction.
- Holding the key in the stop position turn the door handle in an anti-clockwise direction.
- Remove the key from the lock and push the door slightly open.
- Remember to always keep the keys out of sight of prisoners.”

Follow-up to deaths in custody

36. PSO 2710 gives instructions on action to be taken following a death in custody, including the support arrangements for staff and prisoners. The PSO says that priority must be given to communicating the facts about the death to prisoners and staff. It says it may be useful to issue a written statement to prisoners to defuse rumour and myth, but that this will depend on local judgement. Any prisoner who may have been particularly affected by the death should be offered support.
37. A record should be kept of all those entering the area where the prisoner died. There should be an immediate post-incident debrief (a ‘hot debrief’) of staff involved before they go off duty. A senior member of staff should act as a debriefer and a duty care team member identified and, if necessary, called in on duty (PSO 2710, Chapter 5.)

KEY FINDINGS

May 1988 to September 2003

38. In May 1988, the man was arrested and charged with murder. He appeared in court, was remanded in custody and taken to HMP Lewes. Following reception, he settled well into prison life with no apparent problems. However, it was noted that he was a carrier of hepatitis B and that he was addicted to Valium. A Valium reduction plan was prescribed. In March 1989, he was sentenced to life imprisonment at Lewes Crown Court. Following sentence he returned to HMP Lewes.
39. In May 1989, he was moved to the Lifer Unit at HMP Wormwood Scrubs where the LSP was written. The main risk factors identified were drug and alcohol abuse, the use of violence and his offending lifestyle. Whilst in custody he completed a number of offending behaviour courses including:
- Drug Rehabilitation
 - Cognitive Behaviour
 - Alcohol Awareness
 - Reasoning and Rehabilitation
 - Health and Safety
 - Life Skills
 - Assertiveness

An ongoing target was that he should remain free of adjudications, drugs and alcohol.

40. In September 1993, he transferred to HMP Kingston and while he was there he had weekly sessions with the CARATs drugs team. In October 1994, a F2052SH was opened. This was because he told staff that he could not take it and that he was struggling with life in prison. The F2052SH was closed on the same day.
41. The man transferred to HMP Bristol on in December 1994. In August 1996, a further F2052SH was opened because he had self-harmed and told staff that he was on a hunger strike. This F2052SH was closed two months later. In November 1996, he transferred to HMP Swaleside.
42. The man transferred to HMP Grendon in February 1998. Just over two years later (June 2000), a third F2052SH was opened because he talked about his suicidal intent. This one was closed in July. Whilst still at Grendon, a fourth F2052SH was opened in October 2001 and closed two days later. This time, he had talked about being depressed.
43. In November 2001, he made a progressive move to HMP The Mount. However, in February 2003, a fifth F2052SH was opened. The man had made superficial lacerations to his wrist but taken a large overdose which was considered to be a serious suicide attempt. (He had taken a week's supply of

medication.) This coincided with the negative feedback from a parole review. This F2052SH was closed on in March.

44. In May 2003, the man had served his tariff (15 years). He was transferred - for what proved to be the final time - to HMP Kingston in September 2003.
45. During his time in prison, he had a number of health concerns which are explored more fully in the clinical review. They include the after effects of a road traffic accident in 1972, hand problems, back pain, tinnitus, hepatitis B and C, hernia repair, weight loss, food refusal, poor mental health, medication use and misuse, and substance misuse.
46. Entries in his prison records depict him as a man who was very skilful in getting his own way, particularly with medication. Staff describe a grumpy, but likable old man, who had a good but very dry sense of humour. It appears that he was a vocal complainer and always had an 'axe to grind'. The man was repeatedly warned about the untidiness of his cell, which was dirty and cluttered. I have no doubt that he was a challenging man to manage.

September 2003 to September 2004

47. The first 12 months the man spent at Kingston following his transfer were relatively uneventful. He appeared to settle well and with no apparent problems. His drug test samples were negative as they had been for a few years.
48. On first arrival at Kingston, he was in possession of a TENS pain relief machine. This is a battery powered electrical unit which uses electrodes placed onto the skin to deliver electrical impulses to the nerves. It is used to provide pain relief by blocking pain signals to the brain. At some point, the machine broke (the record is unclear when) and was not replaced. Records do not indicate what, if any, relief or benefit he got from the machine.
49. Shortly after he arrived at Kingston, he was introduced to his personal officer. His personal officer would keep an eye on him, as well as keeping a record of events in his history sheet and contributing to review boards, assessments, etc. The man and his personal officer maintained a fairly reasonable working relationship.
50. Also within a few days of arriving at Kingston, the man met a prisoner he had known more or less since entering custody as a lifer but whom he had not seen for a few years. The fellow prisoner told my investigator that he was surprised by the deterioration in the man's physical condition. He said the man was frail and struggled to walk and carry his own meals.
51. The man had his first escorted town visit on 10 June, whilst at Kingston prison. No concerns were raised and the officer complimented his behaviour, politeness and consideration.

52. In July 2004, the Parole Board Panel considered his case and recommended that he was suitable for Open Conditions, and awaited final confirmation of the decision. The man provisionally requested a transfer to HMP Leyhill so that he could consider release to a suitable hostel in the area. Plans were made for him to have an escorted visit there in September.

September 2004 – May 2005

53. On 14 September, the man and the escort officer left Kingston at 8.30am to go to Leyhill, but did not arrive until 2.40pm. The officer reported that their journey was delayed by a traffic accident, bad weather, getting lost and frequent stops because of the man's health. The Area Office investigation discovered that when the man and the officer reached Leyhill, the principal officer who received them decided that the visit should be postponed because of the man's poor mobility and because of the time needed for the return journey. In the course of the return journey another stop was made so that they could use a supermarket toilet.
54. The escort officer searched him on the wing when they got back to Kingston, and has prepared a statement for the Area Office in which he states that the man did not appear to be under the influence of alcohol and had none in his possession.
55. The same day the results of a parole review were confirmed and the man was not to be released, but would progress to 'Stage Three' and was eligible for open conditions. He was told the result of the parole review at 6.30pm after he returned from the visit and the officer noted that the man appeared "a bit down" and had not had a good day as it was a long journey and his back had troubled him so that he could not get out of the car at Leyhill.
56. Less than an hour later, at 7.45pm, the man went to the wing office and staff noticed that his speech was slurred and he was unsteady on his feet. He asked to go to the main prison to see a principal officer, but was persuaded to return to his cell. At 11.00pm his behaviour had become disruptive and he was segregated overnight, suspected of being under the influence of alcohol or drugs. He was examined by a doctor who determined that he was under the influence of drugs.
57. The next day an officer asked other prisoners whether there was alcohol on the wing, and a prisoner directed him to the man's cell where he handed over a bottle of lemonade. The prisoners said that the man had been drinking from the bottle before he was removed from the wing. The bottle was subsequently handed to officers searching cells. Later in the day one of the officers searching cells was approached by a prisoner who said that he had removed a bottle of lemonade from the man's cell and handed it into the office.
58. Subsequently the man underwent a urinary drug screen, which produced a negative result. He later alleged that he had been set-up by his escorting officers whom he said had taken him to a pub. In protest, he refused food for a short time. The allegations were investigated by the prison but there was no

evidence to substantiate them. I have not myself investigated the matter further and have relied on the prison records and the Area Manager's investigation.

59. The Area Manager has concluded that from the information available there was no evidence that the man was under the influence of either alcohol or drugs. In particular there are no records of any adjudications arising from the incident, nor any entries in his medical records.
60. From February 2005 onwards, drug tests on him were positive on eight occasions. They include four findings for opiates, three for cannabis, four for benzodiazepines and one for amphetamines. The medical records state that he was prescribed opiates and benzodiazepines for pain relief.
61. In February 2005, evidence suggested that he had been punched. It is speculated that he was being bullied for his medication. However, there was a concern that he was selling his medication, possibly to obtain other drugs.
62. In April 2005, the man was told that he was on the waiting list for a transfer to HMP Ford, a category D open prison. The same day, he told his personal officer that he had had his medication stolen and was being bullied. However, he refused to give further information and said that he did not want any action taken. He simply wanted his medication replaced. He made similar allegations in May.

May 2005 – June 2006

63. For the next 12 months, he appears to have been relatively stable. His last mandatory drug test was conducted in March 2006, and he tested positive for opiates and benzodiazepines, which was consistent with his prescribed medication.
64. A prisoner told my investigator that during May 2006 the man had said to him that he was feeling fed-up, saw no future and wanted to die. The prisoner said that he felt the same, and they had a discussion about a suicide pact and decided they would overdose on heroin. Although the man appeared to mean what he said, he said he did not take this too seriously, particularly as it was not discussed again.
65. A psychology report, dated 31 May, recorded that it was difficult to recommend further offending behaviour courses, given the number he had already attended and his general ill health.
66. A self-harm document (ACCT) was opened on 14 June after he told a wing officer that he was having thoughts of suicide, and that he had told friends not to grieve for him as he could no longer cope.
67. That afternoon a wing officer assessed the man as part of the ACCT process. He said that he was feeling suicidal and low in mood for a number of reasons:

- his deteriorating medical condition
- he claimed that he was being bullied for his medication
- he did not feel safe around young prisoners
- his perception of injustice following his unsuccessful town visit in September 2004
- the fact that he was still in prison over three years beyond his tariff date.

Despite this, he said that he had no intention of committing suicide, as he said he had the coping skills not to do so. He said that he wanted to be released from prison.

68. On 15 June, the first multi-disciplinary case review was carried out where much of the above was repeated. Additionally, the man said that he was not eating on a regular basis. A care plan was developed to help him cope with the things that were troubling him. During the review, he was reminded that the Listener scheme was available to him. The ACCT document shows that he asked to see particular Listeners frequently. However, if one of them was not on duty and another Listener was offered, he would refuse to see them.
69. The same evening the man told a prison officer that he was concerned about a psychologist's report written for his forthcoming parole review. The officer discussed the points of concern and attempted to reassure him. He also pointed out that the man was doing his cause no good by not eating properly.
70. On 16 June, the CPN assessed him. He was described as being low in mood and "rambling and jumping from subject to subject" in his conversation. The man said that he had not eaten for eight days and that he intended to stop drinking. This was a protest against the prison's interpretation of events surrounding the town visit in September 2004 and his positive drug tests. The CPN was unable to finish the assessment because limited time was available. However, she was not sufficiently concerned that the assessment needed to continue and decided to finish it the next day. Later that evening, the prison officer found that the man was chatty and generally in a good mood.
71. The CPN saw him again the next day to finish the assessment. Afterwards, she was concerned for his mental health. Additionally, he said that he would kill himself should his physical health become too bad for him to cope with. The CPN thought that he might benefit from being located in a prison with 24 hour healthcare facilities and a referral to the healthcare centre for further assessment, but did not write either suggestion in his medical records.
72. A healthcare assistant spoke to him on 21 June. He said that he felt like ending his life, and mentioned that he was thinking of cutting himself. Again there is no note of the conversation in his medical records. He said that he was still drinking copious cups of tea with sugar, but that he was not eating. However, he said that he was eating a biscuit with his medication.
73. The man saw the governor on 23 June and was able to discuss his grievances. Although he did not settle all the issues, the governor made assurances that he would look further at the unresolved issues. Since the draft report was

published, the Area Manager has investigated the outcome of the meeting, but has found no evidence that it took place.

74. The same day, the man was again reviewed by the CPN. The man was described as confused, said he was not eating and was constipated. The CPN formed the opinion that he was suffering from toxic confusion. She discussed this with the doctor and the man was given an enema which the CPN thought would improve his condition.
75. A second multi-disciplinary case review took place in June where the man talked about his current feelings. He told staff that he would not be eating until he had a satisfactory answer from the governor. It was noted that he was taking fluids and was collecting his breakfast pack on a daily basis. He was encouraged to eat, and healthcare agreed to monitor his weight and medication. He was told that staff would check him closely.
76. Also in June, the man was issued with a copy of the dossier that was to be considered by the Parole Board in September. He appeared happy to have this dossier. His personal officer told my investigator that, in the build up to the parole hearing to consider the possibility of him transferring to open conditions, the man was visibly apprehensive and quieter than normal, and spent a little more time in his cell. Despite this, he was not acting in a way that cause his personal officer to be concerned about him.
77. The Area Manager has noted that his medical records contain an entry that the healthcare assistant, in agreement with the doctor, said that he could use his night medication during the day if he needed to. He said that he had deliberately self-harmed by burning the top of his left arm with a cigarette. He would not let anybody see the burn.
78. Healthcare staff audited the medication that the man had in his possession on the morning of 30 June. There were discrepancies in the Nitrazepam that he could not account for. It was clear that he was under the influence of sedative medication.

July – September 2006

79. At 12.35pm on 5 July, the man was discovered with self-harm scratches on both of his wrists. The medical records describe them as deep wounds caused by a razor blade, which were oozing blood. He was treated and placed in a 'safer cell' overnight. That afternoon, the ACCT document was reviewed. (This is mandatory following any incidence of self-harm.) During this review he said that he was going to kill himself, but later he assured the review team that he would not do so. The man once again said that he was awaiting an answer from the governor.
80. Healthcare staff again audited the medication that the man had in his possession on 5 July. On this occasion, he had no medication and said that he had taken it all. He refused to discuss the issue further. However, this was not treated as an overdose, simply that the medication had been used quicker than

it should have been. The Area Manager has been unable to locate the man's medication records and so it is unclear what had been dispensed, and assumed that healthcare thought it insignificant.

81. A wing officer brought the man a bowl of soup and a roll. Half an hour later, he said how much he enjoyed the meal and asked for more soup and another roll which the officer supplied.
82. On 6 July, as there were discrepancies with his in-possession medication, he was told that he must collect his medication from the medical room hatch rather than being allowed to collect it weekly. The man was not happy about this and complained regularly. His personal officer thought that this was because he did not have control of the medication, rather than it being physically demanding for him to collect it. The man said that his objection was due to the sleeping medication being issued at 4.00pm. As a result, he would sometimes be asleep at 5.30pm, but awake again at 3.00 or 4.00am.
83. The same day, the man told a prison officer that he was being bullied by four prisoners and supplied the three names that he knew. This was dealt with under the anti-bullying policy. That evening, his personal officer spent about 20 minutes with him and found him to be in a better frame of mind and chatty.
84. On 8 July, the man told staff that he was now eating properly and feeling more positive about the future. The ACCT document was further reviewed by a multi-disciplinary team on 9 July. This review included his personal officer. The review was earlier than planned as the man appeared to be more positive in his outlook. He said he felt a lot better and was not going to self-harm or attempt to commit suicide. The Area Manager has advised that his medical records for 9 July describe the wounds as caused by a razor blade and that they were oozing blood.
85. On 12 July, a multi-disciplinary case conference reviewed him for the fifth time. He appeared a little confused, but said that he was eating and drinking regularly. Physically, he was unkempt, dirty and had strong body odour. He said that he had been struggling with his pain, as his medication had been reduced and that was still waiting for an answer from the governor. He was referred to healthcare, to the CPN and to the consultant psychiatrist for assessment.
86. The man fell over on the wing on 17 July. As he was suffering with pain in his hip and was taken to the local Accident and Emergency Department. He was treated and returned to the prison that afternoon.
87. On 18 July, he appeared to be quite jolly. The ACCT document was again reviewed on 19 July. The review team was not multi-disciplinary on this occasion, as there was no input from the Healthcare Centre. He confirmed that he was eating and had no thoughts of suicide or self-harm.
88. The CPN saw him on 20 July, and found that he was still a little confused but had improved his appearance and cleanliness.

89. The ACCT document was reviewed on 26 July. This seventh review was the last one, as the multi-disciplinary team, including his personal officer, decided that the document could be closed. At the review, he said that he had been having problems with another prisoner who had now been moved from Kingston. This made him happier. He said he was not being bullied any more and had no intention of committing suicide or harming himself. The man was made aware of the support network available and the ACCT was closed.
90. On 27 July, he had a conversation with a wing officer and said that he was unhappy with the way healthcare was treating him – in particular, the fact he had to collect his medication rather than being allowed to keep it in possession. He complained that he had to take his night medication at 4:00pm, supervised at the medication hatch, rather than being trusted to take it at 9:00pm in his cell.
91. The man was reviewed by the CPN on 11 August. He still presented as being confused, but was generally calmer. He said he was tearful in the mornings. He discussed the forthcoming Parole Board review and felt that he was likely to be released on licence.
92. The man was reviewed again by the CPN on 18 August. He presented as low in mood, but thought it was because he was in pain. The man again said that he felt he was likely to be released on life licence.
93. On 24 August, following a cell search, he was found guilty at an adjudication for being in-possession of medication that was not prescribed to him. The same day, he was assessed by the consultant psychiatrist. He said that he was no longer tearful and that his mood was generally better.
94. A post closure ACCT interview was conducted by the PO and his personal officer on 6 September. The man said that he was very disappointed and angry that he was not allowed his sleeping tablets in possession. Whilst the reviewers concluded that he was not at risk of suicide or self-harm, they felt that his health, mobility and state of mind were deteriorating. A decision was made to refer him to be assessed for a transfer from Kingston to a prison with a healthcare centre offering inpatient facilities. The PO made a referral to healthcare on 11 September.
95. The Parole Board hearing took place on 13 September and afterwards it was recorded in his records that he felt it went well, but he was resigned to staying in category C conditions. The Board concluded that he should remain at Kingston, pending further work on anger management and a period free from substance misuse. Both he and his personal officer presumed that events surrounding the town visit when he was found to be intoxicated were a key factor in the Parole Board's decision. The man expected formal notification of the Board's decision in about 14 days.
96. The Parole Board had previously concluded that he remained a significant risk, and had judged that he was not suitable for transfer to an open prison. The link

between his use of alcohol and illegal drugs and his offending behaviour was a major factor in these decisions.

97. The man was seen and assessed by the consultant psychiatrist on 14 September. During the assessment, he complained of a disturbed sleep pattern which he attributed to having to take his sleeping medication (Nitrazepam) at 4:00pm. He assured the doctor that he would not have this medication taken from him, and that he would use it responsibly at 10.00pm each night.
98. The consultant psychiatrist agreed to a four week trial period. The consultant psychiatrist told my investigator that he discussed this decision with the duty nurse. However, the duty nurse told my investigator that she found out after the consultant psychiatrist had left the prison, and did not have the opportunity to discuss it with the doctor. The duty nurse consulted other healthcare colleagues and, for reasons of practicality, decided that the man would collect a single dose of night medication at the hatch when taking other medicine at 4.00pm. He would then have to return the next day with the empty foil packets to receive that evening's dose. The man returned the empty foils on a daily basis, and his cell was checked weekly.
99. Formal notification of the Parole Board's decision was not received until after the man had died. But during a conversation with his personal officer on 16 September, he was clear that he thought the result would be negative.
100. His personal officer last saw him on 21 September. It was about lunchtime and he was in the queue for medication. He was again complaining about having to collect his medication rather than keep it in his cell. Looking back, his personal officer remembers him being perfectly normal that day. Even with the benefit of hindsight, nothing strikes her as different about him in any way.
101. Later that day, the consultant psychiatrist attended the prison to see the man as planned. However, he did not attend and the doctor was unable to locate him (the doctor did not have security clearance and therefore could not carry keys). Normally the doctor relies upon the CPN to find prisoners, but she was not in the prison and nobody else was available. Regrettably, the doctor was unable to carry out the assessment.
102. A fellow prisoner who was in the cell next to the man's cell, told my investigator that three or four prisoners (including himself) would help him with the collection of meals and cleaning as he was unsteady on his feet.
103. The prisoner said that the man would regularly talk about committing suicide, and said this was because he was unhappy about the care he was receiving from healthcare. He had not taken the man's comments seriously, saying that the man had "cried wolf" too often. The last time he remembers the man talking about suicide was around 21 or 22 September. He said that he told a male member of staff but could not remember which one. Allegedly, the officer told him that he would tell healthcare. I have found no other record of this conversation, nor of any action being taken.

24 September 2006

104. A prison officer knew the man reasonably well and saw him around lunchtime when she came on duty. She remembers that he was perfectly normal and said "hello" to her.
105. At 3:00pm, the duty nurse attempted to audit the medication that the man had in his possession. On this occasion, his cell was so untidy that the audit was abandoned without finding any medication.
106. A prisoner saw the man in his cell in the afternoon and found that he was acting normally. He did not think that the man was in any way vulnerable. Another prisoner, who had been acting as a Listener for the man regularly saw him that afternoon as a friend. He told the police that when he saw him he was his normal self, and he had left him with no concerns.
107. At 4.00pm, the duty nurse issued him with his medication. Apart from his regular complaint about not being allowed his medication in possession, she told my investigator that there was nothing different about him that day, and she was not concerned about him.
108. About 4.15pm, another prisoner saw him in his cell for about 15 minutes. He told my investigator that the man seemed to be the happiest that he had seen him. They had a bit of light hearted banter together whilst the man ate two sardine rolls. The fellow prisoner left the man in his cell, as it was time for the prisoners to be locked in for the evening. He was not left with any suspicion that the man was vulnerable to suicide or self-harm.
109. The fellow prisoner had been at Kingston for about three months and had built up a friendship with the man, spending a lot of time in his cell chatting. He was young and more mobile than the man, and would help him by collecting his meal and making sure he had what he needed before he was locked in his cell. He would also ensure that the man remembered to collect his medication.
110. At about 8.00pm, the wing officer checked the roll on D wing by checking each cell and verifying the number of prisoners on the wing. This is a counting procedure and not a welfare check. It takes place at the beginning and end of each shift to ascertain the number of prisoners being handed over to the next shift. Whilst not checking in any great detail, the officer remembers that the man was sitting on his bed but cannot recall what he was doing.
111. One Senior Officer (SO) and two prison officers were on duty overnight. The evening roll check was completed by both of the officers. Neither could remember who checked the man's cell, but neither recalled anything unusual about the roll check. Overnight, the staff heard nothing unusual on D wing and were not called to the man's cell for any reason.

25 September 2006

112. During the morning roll check, a prison officer counted D wing prisoners at 5.50am. He could not remember anything specific or suspicious about the man's cell, only that there was enough natural light to establish that there was a prisoner in the cell.
113. At 7.00am, another officer conducted a further roll check of the prison. The natural light was low, so the officer briefly switched on the light in each cell, verified the prisoner was present, and continued around the wing. At the man's cell, the officer put the light on, saw a hand on the sheets and, having verified that the man was present, switched the light off and moved to the next cell. When the roll check was complete, he returned to the centre and signed the roll check document confirming that he had seen 192 prisoners.
114. At 7.45am, the duty SO gave permission for staff to unlock all of the cell doors, and the wing SO unlocked all the cell doors on D1 landing. To do this, the wing SO simply opened the lock and left each door open about four inches. He did not open any of the observation flaps or look into the cells. When he opened the man's cell, he opened the door without resistance and moved on to the next cell. The wing SO told my investigator that some staff open the observation flap and look inside the cell, but his practice is not to do so.
115. Once the wing was unlocked, the SO remained on the landing until he was content that the wing was operating normally. About three quarters of the prisoners came out of their cells, but the man did not. This was not a surprise to the SO, as he knew that the man would stay in bed until he had to go to the medical hatch. Once the wing was settled, the SO went to the security department where he normally worked.
116. A fellow prisoner passed the man's cell and pushed the door open a little and realised the bed was blocking the door. He said that the man did this regularly, although the Area Manager states that there is no evidence of previous occasions. He told the man that he had a tea kit for him and threw it on to the edge of his bed. He then left the cell assuming that the man was lying in.
117. Another fellow prisoner also went to the man's cell, as he did every morning, to ensure he was out of bed and ready to collect his medication. The door was unlocked, but not opened more than a few inches. When he pushed the door it was clear to him that there was an obstruction and the door would not open beyond six or seven inches. He looked through the cell observation flap and noticed that there was something wrong as he could not get a response. On closer inspection, he realised that there was a plastic bag covering the man's head. He immediately went to alert the duty SO.
118. At about 7.49am, the duty SO and two officers were in the prison centre (this is where the ends of the wings meet and provides a good all round observation point). The prisoner approached and asked the duty SO if anybody had checked on the man, as he could not get a response from him. He did not mention the plastic bag.

119. Two officers went to the cell and could not open the door. The first officer pushed harder against the door and was able to open it sufficiently to see that it was blocked by the bed and a painting easel. The second officer beckoned for the duty SO to attend, and then went to healthcare where she found the duty nurse
120. The staff at the cell managed to move the bed back enough for the first officer to enter the cell and completely remove the obstruction. Once in the cell, staff could see that the man had two of the breakfast pack plastic bags over his head. They were taped around his neck with a roll of brown parcel tape. He was lying on his back, with the covers pulled up to his chest by his hands, which were visible over the covers. The duty SO raised the alarm using the radio system.
121. The duty nurse was in the healthcare centre and, before the radio alarm was raised, she was alerted to a problem by the second officer. The nurse did not know what the problem was, but from the officer's demeanour realised it was urgent. However, the nurse did not enquire into the nature of the problem and did not take the emergency response bag with her.
122. At the same time that staff gained entry to the cell, the duty nurse arrived. The nurse checked him for signs of life, but could not find any. The nurse was certain that the man was dead and decided that any attempts at resuscitation would be futile.
123. Soon afterwards, paramedics arrived at the cell, and confirmed the assessment made by the duty nurse. At about 8:15am, a doctor arrived at the cell and after an examination certified that the man had died. The doctor told my investigator that the man's body was in the early stages of rigor mortis.

Events following the death

124. The wing SO secured the cell door with a security lock, and the cell was treated as a potential crime scene until the police arrived. The SO told my investigator that he looked through the observation flap. Even in the improved light, he struggled to see the bag on the man's head. He said that observation was made difficult by the untidy condition of the cell, particularly as many objects were piled around the bed.
125. The staff involved submitted comprehensive statements to the governor, providing a detailed account of the discovery and management of what had occurred. Other paperwork was completed subsequently to record events in accordance with the local contingency plans for a death in custody.
126. At 10.00am, all staff involved attended a hot de-brief which was chaired by the duty governor. Staff were able to talk through the sequence of events and were offered support.

127. The prisoner in the cell opposite the man who died told the police that the man regularly said, "I might as well get it over and done with; I'm going to die in here anyway."
128. On a number of occasions during his time at Kingston, he was warned that his cell was in an unacceptable condition. On his first visit, my investigator looked at his cell before it was cleaned and found it very dirty and untidy. There was property piled around the cell, with no apparent control of its volume exerted by the prison.
129. There was no formal announcement of the man's death and staff learnt principally by word of mouth.
130. The post mortem concluded that the man died from asphyxia. It also showed there were no defensive marks or evidence that a third party had been involved. The police investigation also confirmed that there are no third parties involved and that there are no criminal issues.
131. The man had no next of kin registered, but the prison knew that he had a brother so the duty governor asked the police to trace him. The police found his address and were able to inform him of the man's death. His brother explained that they were not close. The prison was asked to make funeral arrangements locally.
132. Photographs were taken of the cell as part of the police investigation. The area manager described the photographs showing the man's hand outside the bed, placed on his chest, in front of the brown tape used to seal the plastic bag round his neck and head. The police investigation established that the plastic bags that he used were those supplied by the kitchen with the breakfast packs. The bags are un-perforated, measure 18 by 24 inches, and are of a slightly frosted appearance.
133. The tape that was used to secure the plastic bags around his neck was the inch and a half wide brown parcel tape used by prisoners in the workshops. This tape is not issued to prisoners, but is not an item that is separately controlled and accounted for. As he did not go to the workshops, the police could not establish how he was in possession of the tape.
134. Some of the prisoners whom my investigator spoke to said that the man was being bullied by healthcare staff into taking his medication in front of them, rather than later in his cell. Others told my investigator that he was unhappy with his medical treatment. The man's fellow prisoner and friend said that it was the worst prison healthcare he had seen in 21 years. In contrast, another prisoner said that he has confidence in healthcare at Kingston, and that he was treated very well.
135. My investigator was also told that the man was too infirm to collect his meal unaided, but that prisoners would assist him as staff would not. There is a stair lift, but it had been broken for a long period of time. When my investigator checked, the stair lift was working. Prisoners told my investigator that they

thought he should have been in a specialist environment for the elderly or in full-time healthcare.

ISSUES

Roll Checks

136. The fact that the man was discovered by another prisoner, after two different officers had checked the cell to count the roll and a senior officer had unlocked the cell door, is both surprising and disappointing. National instructions are clear; the officer must gain a response from the prisoner. However, in common with many prisons, custom and practice seems to have developed at Kingston into officers simply checking the roll and not that the prisoners are alive. (The motive is a benign one: to avoid disturbing prisoners unnecessarily.)
137. National guidelines instruct staff to open the door observation flap, and check inside a cell before opening it. Again, custom and practice at Kingston has developed into some staff not opening door flaps in order to provide prisoners with privacy. The wing SO did not open the flap to look inside the cell before opening the door.
138. If any of the three members of staff had completed the tasks as they should have been done, then the low levels of light in the cell would not have been a factor in failing to see the plastic bags on the man's head.
139. I acknowledge that the man was likely to have died by the time the wing officer conducted the roll check at 5:50am. However, in other circumstances the opportunity to save a life could be lost.

The governor should remind all staff of the expected standards when they conduct a roll check and when they unlock prisoners. These procedures need to be monitored by managers regularly.

Town Visit – September 2004

140. There is no doubt that the man felt that he was the victim of injustice when he was thought to be intoxicated after the town visit in September 2004. At the time, he denied being drunk. However, he later claimed that the escorting staff had taken him to the pub thus setting him up. The governor at the time investigated the man's claim, but could find no supporting evidence.
141. I have not enquired into this matter further. However, it is clear that the incident became a major factor in his mind and one that would inevitably affect his future. On the very day of the town visit, he was told that he would be able to move to open conditions. This was never formally rescinded, but I suspect he knew that in practice it was unlikely that he would be transferred to an open prison in the foreseeable future. It appears that his strategy was to throw some doubt on the events surrounding the town visit.
142. Whatever actually occurred during the town visit, it was a great concern to him and the focus of much of his suicidal vulnerability. However, it appears that the prison handled his persistent denial and counter allegations seriously, and with patience and professionalism.

Anti-Bullying

143. Kingston prison's local Anti-Bullying Strategy is a comprehensive policy document which is consistent with national policy. The man complained on a number of occasions that he was being bullied for medication. There is contrasting information that suggests that he was actually selling his medication.
144. On 6 July 2006, he told a prison officer the names of three prisoners whom he said were bullying him. This was investigated and dealt with appropriately using the local policy.
145. The prison and the PCT both acknowledge the observations made by HMCIP when the Inspectorate witnessed bullying in the queue for medications. However, my investigator found that the queue was properly supervised and did not witness any bullying.
146. Some prisoners told my investigator that the man was bullied by healthcare staff into taking his medication. It is well documented that he said his medication was being stolen, but that he did not want to have control of his medication taken away. It appears that he had to be encouraged to take his medication at the hatch, but I judge this to have been appropriate.

Suicide and Self Harm Monitoring Procedures

147. Kingston's local Suicide Prevention Strategy is another comprehensive policy document, again consistent with national policy. An ACCT document was properly opened when the man threatened to commit suicide on 14 June 2006. The ACCT was closed on 26 July when he had appeared to improve. My investigator also assessed the five F2052SH documents and found that that were all appropriately handled by the individual prisons.
148. Observations and assessments made in the ACCT are to a good standard. All were multi-disciplinary, with the exception of the sixth case review on 19 July. All reviews explored the issues that were concerning him and concluded with appropriate care plans and observation levels being set. I consider that the ACCT document was managed very well. It provides clear evidence that the man was cared for.
149. The build-up to the Parole Board hearing was clearly having an effect on his state of mind. This was also the case in February 2003 when at The Mount. On that occasion, following a negative parole result, he had cut his wrist and taken a week's supply of medication in an apparently serious suicide attempt. However, the link between Parole Board decisions and the man's risk of self-harm does not seem to have been made by the prison prior to his death.
150. After the Parole Board hearing on 13 September 2006, I have little doubt that the man realised that he was not going to progress quickly to open conditions or to eventual release on licence. This was despite the fact that he had already served three years and four months beyond his tariff.

151. I think it very likely that this realisation, coupled with his increasingly frail health, increased the risk of suicide. However, to the staff and prisoners around him, he appeared to be coping. In fact, it is suggested in the clinical review that the good mood observed in the immediate period prior to his death was an indicator that he had already made the decision to kill himself. An improvement in mood immediately before a self-inflicted death is a recognised phenomenon in the literature on suicide, and has been found in a number of my investigations.
152. When the man did not attend for his appointment with the visiting psychiatrist on 21 September, a nurse or discipline officer should have located him and, with his agreement, accompanied him to the Healthcare Centre. By missing this assessment with the visiting psychiatrist, an opportunity may have been lost to identify the state of his mental health and any suicidal ideation.

The PCT should ensure that there is a follow up procedure when prisoners do not attend for appointments. The procedure must establish a reason for the prisoner not attending and make provision for a repeat appointment if required.

153. In the psychiatrist's view, because of his personality traits and long history of self harming and suicidal behaviour, the likelihood of him completing suicide (in prison or following release) would always be considered to have been high. According to the doctor, at the time of his death the man displayed several risk factors for deliberate self harm and suicide:
- His personality traits suggest that he had poor coping skills at times of stress and tended to be impulsive.
 - There were significant stresses in his life including chronic back pain, tinnitus and ongoing bullying by other prisoners. In addition, he had been expecting bad news from the Parole Board about his future and felt a sense of betrayal by the prison.
 - In the months leading up to his death, the man displayed a fluctuating mental state with episodes of confusion, frank psychosis and clear evidence of a depressive disorder, associated with suicidal thoughts and self harm behaviours. He had lost a lot of weight and was becoming increasingly physically frail.

Psychiatric Care

154. Although he had a long history of drug and alcohol abuse, the man was prescribed medication that was potentially addictive. No single health professional was overseeing this aspect of his care, leaving potential for abuse and exploitation by other prisoners.
155. There is no clear care pathway for patients needing tertiary psychiatric care. In the community, a General Practitioner seeing a patient with depressed mood,

suicidal thoughts, profound weight loss, self neglect and psychotic symptoms, including hallucinations and delusions, would be strongly requesting urgent assessment and possible inpatient psychiatric care.

156. The psychiatric assessment provided for him is not comparable to that he would have received in a standard community mental health team outpatient clinic. A comprehensive risk assessment document would have been completed, as would a full mental state examination. Particularly on a first psychiatric assessment, a written summary of the interview would have been sent to the referring agency, generally the patient's doctor.
157. The quality of the assessments by the CPN was good. She clearly documented her findings, quite often using the man's own words. She appeared to have developed a good therapeutic rapport with the man.
158. Why the consultant psychiatrist made no comment on the man's psychotic symptoms remains unclear. Presumably, the CPN would have mentioned her concern regarding his mental state in her referral to the doctor and subsequent conversations with him.
159. If psychotic symptoms had been confirmed and enduring, the possibility of prescribing anti-psychotic medication would have been an option.

The PCT should ensure that there are appropriate assessments and mental health pathways in place to plan and provide effective mental health care and support.

Medical Care

160. Medical records were generally poor and not to the standards expected by the professional regulatory bodies, and there was no audit procedures for the monitoring of standards of clinical entries. The Nursing and Midwifery Council (NMC) sets standards for entries in nursing notes. These include the need to properly identify who is making the entry.
161. The entries made by the CPN were of a good standard and were legible. They demonstrated both a thorough assessment and a clear conclusion and management plan. The entries made by the Health Care Support Worker (HCSW) were excellent in form and legibility. But other nursing note entries did not meet the NMC standards and were generally too brief.
162. The doctor's entries made in the man's clinical record are not of a satisfactory standard. The entries are often difficult or not possible to decipher, at least in part. Both written and computer entries are too brief, and are not sufficient to provide evidence of adequate history taking or examination.
163. Communication at the time of the man's death within the healthcare team and with mental health professionals was ineffective. As a result of poor communication and a failure not to look back at recent clinical entries, the concerns of the CPN and the PO went unnoticed.

164. During the course of his food refusal, and while on the ACCT document, the man lost 12lb. This was a significant amount of weight loss for an already thin and frail man. The Healthcare Centre does not have a formal procedure for monitoring food refusal. The absence of a written food refusal policy is likely to lead to inconsistent care.
165. A TENS machine should have been obtained and provided for him. He was on large doses of a strong opiate painkiller and the use of this medication was a concern because of its potential for misuse and the resultant risk of bullying.
166. Evening medication had either to be given in-possession, or taken under supervision at 4:00pm. It is not reasonable to expect patients to take sleeping medication at 4:00pm.

The PCT should review the nursing hours available in the prison, so that evening medication may be supervised at more appropriate times.

167. Requests for the man's transfer from Kingston appear to have gone unheeded. Given that from March to August inclusive there was no visiting consultant psychiatrist at the prison, the onus was very much on the doctors to back up the CPN.
168. Serious concerns were documented by the CPN on four occasions. On 12 June 2006, she believed that the man was unfit to be held in Kingston and that he should be transferred to the healthcare wing at Winchester for 24 hour health care.
169. Following the entries by the CPN, subsequent GP entries show no recognition of her concerns, nor does there appear to be a response to her requests for a GP review of the man's physical health.

The head of healthcare should ensure that appropriate follow up action is taken when a prisoner is referred to healthcare for assessment.

170. Given the fact that from March to August 2006 inclusive there was no visiting consultant psychiatrist at the prison, the onus was very much on the GPs to provide a medical input to mental health provision to back up the Mental Health Gateway Worker.

The head of healthcare should ensure that alternative arrangements are made if there is a shortage in the provision of mental health in reach services.

171. The man claimed that he was being bullied for his medication. However, there is security information that he was selling his medication, intelligence that may be validated by the fact he was failing his drug tests. I am unable to say what happened to his medication, but it is manifest that the man was not taking it as prescribed.

172. When it became apparent that the man was not taking his medication, it was appropriate that he was no longer allowed to retain it in his possession. However, it was not reasonable to expect sleeping medication to be taken at 4:00pm. The subsequent decision to allow the man his sleeping medication in-possession, on a daily basis, was therefore entirely appropriate. Since his death, I am pleased to see that the prison and the PCT have extended the treatment times to allow medication to be given in the evenings.

The head of healthcare should ensure that doctors do not make decisions about whether a prisoner is allowed to keep medication in their possession without consulting other members of the multi-disciplinary team.

173. Prisoners have expressed differing views on the quality of healthcare provision at Kingston. From the evidence, documentation and findings of the clinical review, it appears that the healthcare team were working hard to provide a decent service for prisoners. In general, I judge that they are moving in a positive direction.

Emergency Response

174. Once staff were alerted to the man's condition, staff responded immediately and appropriately. The wing officer acted quickly in locating the duty nurse. However, the officer did not tell the nurse the nature of the emergency. The nurse realised that the matter was urgent but did not enquire as to its nature. Consequently, the duty nurse responded without any emergency equipment.
175. Whilst I acknowledge that it made no practical difference in this case, a practice of not taking the emergency bag to urgent calls is not supportable. It must become established practice for emergency equipment to be taken to all emergency calls.

The head of healthcare should ensure that nurses called to an emergency situation take the emergency bag with them.

176. The decision not to attempt resuscitation was appropriate and consistent with national guidelines.

Cell Furniture

177. The untidy condition of the man's cell was unacceptable. I acknowledge that he was told to clean his cell on a number of occasions, but his refusal to maintain a tidy cell appears to have been ignored. It may be that he felt unable to clean the cell, due to his physical ill-health. But in that case staff ought to have made alternative arrangements. In any event, the prison ought to have actively reduced the volume of property that he was allowed to keep in his cell.
178. When it became clear that it was not possible to assess whether or not he was hoarding his night medication, the giving of this medication in-possession should have been discussed with the visiting psychiatrist or one of the GPs,

with a view to discontinuing it. In any event, a comprehensive cell search should have been conducted by the discipline staff.

Events following the man's death

179. The man was found dead on the third anniversary of his arrival at Kingston. I can see nothing that indicates this was anything other than a coincidence. I have not been made aware that the date was significant to him in any way.
180. PSO 2710 requires that the holding of a hot debrief. This took place and it appears that all staff involved were able to contribute. Support to officers, healthcare team members and other prisoners was also given.
181. The reports submitted to the Governor by staff were detailed and comprehensive. This was both helpful to my investigator and prevented some staff being interviewed needlessly.
182. The wide availability of plastic bags in the Prison Service is not normally a concern. However, this is the second death my office has investigated which has resulted from asphyxiation using such a bag. I note that the bag in this case was not perforated. It would be circumspect for the Director General to consider the safety implications of the bags used in prisoners' wastebins and breakfast packs. The man was also able to obtain parcel tape from a prison workshop, although the means by which he did so are unknown.

The Director General of the Prison Service should commission a short review of the types of plastic bag that are readily available to prisoners and the safety implications thereof.

RECOMMENDATIONS

National

1. The Director General of the Prison Service should commission a short review of the types of plastic bag that are readily available to prisoners and the safety implications thereof.

The recommendation is partially accepted by the Prison Service.

Since the publication of the draft report, I have been advised that the Safer Custody Group carried out a review in July 2004, and concluded that restriction of one means of self inflicted death usually leads to greater use of alternatives. Unless an individual ACCT plan determines that plastic bags should not be supplied to a prisoner, they would not be singled out by automatic removal of items such as plastic bags, which may increase the incidence of bullying of vulnerable prisoners.

Local

2. The governor should remind all staff of the expected standards when they conduct a roll check and when they unlock prisoners. These procedures need to be monitored by managers regularly.

This recommendation has been accepted. A notice has been issued to staff and all line managers have been informed of their responsibility to ensure that staff carry out their duties correctly.

Healthcare

3. The PCT should ensure that there is a follow up procedure when prisoners do not attend for appointments. The procedure must establish a reason for the prisoner not attending and make provision for a repeat appointment if required.

The recommendation has been accepted and the healthcare team is developing a process which will be completed by August 2007. A record is now kept of all prisoners who fail to attend healthcare appointments.

4. The PCT should ensure that there are appropriate assessments and mental health pathways in place to plan and provide effective mental health care and support.

The recommendation has been partially accepted and the Service Level Agreement with the Mental Health Team is under review, for completion by August 2007. The Primary Care Trust have established a weekly psychiatric clinic, part time clinical psychologist and increased the service provided by the psychiatric nursing service.

5. The PCT should review the nursing hours available in the prison so that evening medication may be supervised at more appropriate times.

The recommendation has been accepted and the nursing hours extended to 6.00pm. Evening medication is now dispensed between 5.30 and 6.00pm, and all prisoners are assessed to determine whether they can hold their own medication.

6. The head of healthcare should ensure that appropriate action is taken when a prisoner is referred to healthcare for assessment.

The recommendation is accepted.

Agency nurses are being trained to use the same recording system as those employed by the PCT. All nurses are being provided with triage and physical assessment training. The introduction of a nurse led service has also improved the doctor's documentation.

7. The PCT should ensure that alternative arrangements are made if there is a shortage in the provision of mental health in reach services.

The recommendation is accepted.

Alternative provision is available from the AMH Crisis team or duty psychiatrist to cover the absence of any of the usual practitioners.

8. The head of healthcare should ensure that doctors do not make decisions about whether a prisoner is allowed to keep medication in their possession without consulting with other members of the multi-disciplinary team.

The recommendation is accepted, and team meetings and handovers have commenced.

To reduce the risk of prisoners being bullied for their medication, a system has been introduced to reduce the amount of opiate medication in circulation. Prisoners take their morning dose in the presence of a trained duty nurse and collect their evening dose at tea time.

9. The head of healthcare should ensure that nurses called to an emergency situation take the emergency bag with them.

The recommendation is accepted.

All nurses employed by the PCT have now completed Basic Life Support (BLS) training and BLS will continue until the paramedic or doctor confirms death. The emergency bag has been re-stocked and portable oxygen supplied.

The response to all Serious Adverse Events now follows the PCT policy and prison staff have been advised to contact the on call PCT manager if a

situation occurs outside healthcare hours. The healthcare hours have been extended from 7.30am to 4.30pm, and are now 7.30am to 6.00pm.