

**Investigation into the circumstances surrounding the
death of a man at HMP & YOI Moorland
in August 2007**

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

March 2008

This young man was just 20 years old when he died on in his cell at HMP & YO1 Moorland. He was found hanging by staff carrying out a routine morning roll check. It is tragic when someone so young apparently decides that they have nothing more to live for. My investigator and I offer our sincere condolences to the man's family and friends for their sad loss.

I wish to thank the Governor of Moorland, for making the necessary facilities and information available to my investigator, and for the assistance of the Liaison Officer. In the course of the investigation, I also asked for a clinical review to be carried out into the care and treatment the man received in custody. I am grateful to the clinical reviewer for this.

The man had been given a life sentence with a minimum term of 12 years imprisonment. There was also evidence that he had felt bullied by other prisoners, albeit the most recent incident was a month before his death. However, he gave no indication to prison staff that he was feeling suicidal. In fact, the opposite appears to have been the case.

My report makes one recommendation for the prison and identifies one example of good practice. This version of the report has been anonymised for publication on the PPO website.

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SUMMARY

The man was sentenced to life imprisonment at Newcastle Crown Court on 20 January 2006. The judge said he should serve a minimum of 12 years in prison. Once he had been sentenced, the man returned to HMYOI Castington where he had been held on remand. After his needs had been assessed, he was allocated to HMP & YOI Moorland and transferred there on 27 June 2006.

The man appeared to settle in well to his new surroundings and participated in a course designed to meet the needs of life sentence prisoners. However, there are two recorded incidents of him complaining to prison staff that he was being bullied by other prisoners. The complaints were properly investigated and appropriate action taken.

In order to improve his key skills, the man had joined an education class and would eagerly remind prison staff to unlock him for his class. Additionally, he was progressing well in his workplace and appeared keen to please his instructor. In the afternoon of the day before he died, the man had arranged with the instructor to do cleaning work in the workshop at the end of the week.

During a routine roll check during the night of 21/22 August 2007, the night patrol looked into the man's cell at about 5.00am and saw him hanging from the light fitting. She summoned assistance from an officer who was also in the area and at the same time asked for medical help using her prison radio. Sadly, when prison staff and a nurse entered the cell, it was obvious to them that the man had died and resuscitation was not possible.

THE INVESTIGATION PROCESS

1. Once my office had been notified of the man's death by the Prison Service, the investigation was allocated to a member of my staff. He contacted the Duty Governor the same day and agreed with him to meet and open the investigation at the prison two days later (24 August 2007).
2. My investigator was met at the prison by the Liaison Officer and taken to meet the Governor in the prison boardroom. The meeting was well attended and, as well as those previously mentioned, included an Independent Monitoring Board member, the Prison Officers' Association member, a senior manager at the prison, the Residential Manager, and Head of Risk Offender Management. In addition, and at the request of my investigator, I am pleased that two members of Doncaster Primary Care Trust were able to be present. They were Head of Strategic Commissioning with responsibility for prison healthcare, and Assistant Director of Clinical Effectiveness (Clinical Reviewer). Their presence has undoubtedly assisted the preparation of their review and the timeliness of my report.
3. The Governor gave my investigator an overview of what had occurred, after which the investigator and the representatives from Doncaster PCT visited the cell where the man had been found. Before leaving the prison, the investigator gave them the man's medical record for their consideration. Additionally, he identified those members of staff he wished to speak to. He arranged to return to the prison to begin his interviews the next month on 27 September. The following staff contributed towards my investigation, although they were not all interviewed using tape recording facilities:
 - A prison officer for over 13 years. Prior to joining Moorland in September 2004, he had been employed for ten years as a prison custody officer at HMP Doncaster. This prison officer is a member of Houseblock (HB) 4 staff, which is where he has worked since transferring to Moorland. This officer locked the man up for the night on 21 August.
 - A Senior Officer (SO) has been employed by the Prison Service for 17 years. He has worked at Moorland for 15 years and prior to this was an officer at HMP The Mount. This Senior Officer has been an SO for six years and was the night manager on 21 August.
 - A Operational Support Grade (OSG) has been employed by the Prison Service for two years. Her duties include working every four weeks as night patrol. This OSG was the night patrol on HB 4 on 21 August, and found the man hanging.
 - This second prison officer has been employed by the Prison Service for five years. He has been an officer for three years and prior to this was an OSG at HMP Lindholme. This second officer has been employed at

Moorland since February 2006. He was in HB 4 when the man was discovered, and was the first person to respond to the OSG request for assistance.

- A Healthcare Officer (HCO) has been employed as a nurse by the Prison Service for five years. She has a B.Med/science honours degree in nursing as well as a first level nursing qualification. Prior to joining the Prison Service, the Healthcare officer was a nurse at a local hospital.
 - A third prison officer has been a prison officer for three years. She currently works on HB 4 but had previously worked on HB 3. This Officer has provided background information about the man.
 - An Officer Instructor (OI) has been employed by the Prison Service for over 16 years. Before transferring to Moorland in 1998 he worked at HMP Bullingdon and HMP Bellmarsh. He is currently employed as an instructor in a production workshop preparing breakfast packs for the two Moorland sites. This Officer Instructor was the man's workshop supervisor and has provided background information about the man.
 - A fourth Prison Officer has been employed by the Prison Service for 18 years. He was originally based at HMYOI Feltham until he transferred to Moorland in 2000. This Officer is currently employed in the prison's Offender Management Unit and is one of four officers responsible for writing lifer reports. This Officer has provided background information relating to the man.
 - A Probation Officer that has seconded to Moorland. She qualified as a probation officer in 2003 and prior to this worked as a trainee probation officer for two years. The probation officer interviewed the man as part of his life sentence review two weeks before he died.
4. One of my family liaison officers, telephoned the man's mother, in September 2007. The family liaison officer explained my role and offered the man's family the opportunity to meet her and the investigator. The purpose of the meeting was for the man's family to contribute towards my report and ask any questions they would like me to examine. The man's mother decided that she did not require a visit. However, she did want to know if the man had asked to see one of the prison's Listeners the day before he died. My investigator has confirmed with the prison liaison officer that the man did not ask to see a Listener. Additionally, the man's mother asked that my report should reflect how grateful she was for the support she received from the prison. I am pleased to recognise that fact here.

HMP & YOI MOORLAND

5. Moorland prison is a large and complex institution divided between two sites known as Moorland Open and Moorland Closed. Moorland Closed is a training prison for both adults and young offenders. Moorland Open is a few miles away.

Code red and code blue

6. In the event of urgent medical assistance being required, the prison has a radio code system to alert medical staff to the emergency situation. Code red informs medical staff that the patient is bleeding. Code blue alerts them that the patient is in breathing difficulty. The system ensures that medical staff take the correct emergency equipment with them and helps provide the necessary care as quickly as possible.

Her Majesty's Chief Inspector of Prisons

7. In December 2005, Her Majesty's Chief Inspector of Prisons, made an announced inspection of the prison. The inspection found that Moorland was generally delivering a safe, purposeful and resettlement orientated regime. The Chief Inspector added that this was commendable, given the mix of types and ages of prisoners, the range of needs that they presented and the variety of accommodation in which they were held.

Independent Monitoring Board (IMB)

8. Each prison has its own IMB made up of volunteers from the community. The Board's role is to ensure that the prison is properly run and that prisoners are treated decently. Each Board produces an annual report for the Secretary of State.
9. In its most recent annual report (2006), the Moorland Board concluded their summary by saying that the prison was well established and high performing. They added that the prison provides a safe, secure and aesthetically pleasing environment for prisoners, with ample provision for education, purposeful activity and work.

Life Sentenced Prisoner Induction Group

10. The induction programme is aimed at newly sentenced lifer prisoners and provides support by involving other lifers. The prisoners assisting do so by offering their experience and explaining the life sentence process. The induction group is run by the Probation Service and is a question and answer course. Occasionally, there is participation from guest speakers, including former life sentence prisoners who describe what life is like after release.

Listeners

11. Moorland has a Listener scheme (a system where the Samaritans train selected prisoners to be the first contact for any prisoner who is feeling vulnerable and at risk). The scheme is confidential and any prisoner can ask to speak to a Listener at any time of the day or night. Prisoners can access a Listener easily by speaking to a member of staff who will then make the arrangements. During the hours that prisoners are locked in their cells, anyone wishing to speak to a Listener can ask the night staff to arrange it. The Night Orderly Officer has the authority to unlock a Listener and to escort him to the cell of the prisoner who is requesting assistance.

Night state 10.00pm – 6.00am

12. Night state is when the prison is fully locked up for the night and staffing levels are at a minimum. The role of those staff on duty is to monitor the security of the wing and the prisoners held there.

13. At night time, as well as officers and Operational Support Grades (OSGs), there is a Senior Officer (SO) on duty. The SO is responsible for the prison and, in the event of an incident, staff will refer to the SO for advice and instructions. If necessary, the SO in turn will refer to the on call Duty Governor for advice.

14. During night state, it is not normal to unlock a cell unless the night manager has sufficient staff in place to deal with any situation. Night patrol officers do not carry security keys and are therefore unable to move freely around the prison. However, they do carry a cell door key in a sealed pouch secured to their uniform belt. If it is felt necessary to enter a cell in the event of a life threatening situation, the night patrol officer breaks the pouch seal to obtain the key. However, in the first instance, the officer must summon assistance and should only enter a cell on their own, if it is safe to do so.

15. Unlike the night patrol officers, the night manager does carry security keys and is able to move freely about the prison. The manager will usually visit each of the wings during the night and check on the welfare of the staff and ensure they are carrying out their duties correctly

Police investigations of deaths in custody

16. With all deaths in prison custody, the police are notified by the prison as soon as the death has been discovered. In the first instance, the police treat the area where the person is found as a potential crime scene and, as part of their investigation, note the names of everyone involved and those who have been in contact with the body. Additionally, they note the identity of all those entering and leaving the cordoned area. It is only when the police are satisfied that the death is not suspicious that my investigators may begin their own investigations.

Prison Service Orders (PSOs)

17. Prison Service Orders are long term mandatory instructions that are intended to last for an indefinite period. Any mandatory instructions to Governors or Directors of contracted prisons are written in italics. Each PSO is given a title and unique reference number.

Previous deaths at Moorland

18. Since 1 April 2004, my office has been responsible for investigating all deaths in custody. Moorland has had one other death during this period, that of a man who died of natural causes.

KEY FINDINGS

19. On 24 March 2005, the man was remanded into custody to HMYOI Castington. He had been charged with murder. As part of the normal procedure for admitting prisoners into custody, a health screen assessment is carried out by a member of the prison healthcare staff. The clinical review annexed to this report notes that the man was given a detailed health screen and, other than minor medical treatment, he had no significant medical history. The clinical reviewer has considered the man's mental health and concludes that he had no identified mental health problems or known psychiatric history. The man originally told the nurse assessing him that he did not use drugs. However, he later admitted to what is described in the clinical review as recreational drug use. The drugs mentioned in the review include cannabis, amphetamines and ecstasy.
20. The clinical review notes that, whilst at Castington, the man's physical and mental health was regularly monitored. Shortly before his trial, the man was experiencing difficulty in sleeping. A Community Psychiatric Nurse (CPN) assessed him and concluded that he had no mental health problems and that his anxiety was associated with the trial. At the point when the man was due to return to court for sentencing, he was relocated into healthcare for observation. This is normal Prison Service procedure for anyone charged with murder.
21. The man remained at Castington on remand until his trial. He was found guilty on 20 January 2006 and sentenced to life imprisonment. When passing sentence, the trial judge said that the man should serve a minimum of 12 years in prison. This meant that his minimum period of imprisonment would have taken him to 21 April 2017.
22. Following the trial, the man was taken back to Castington. Once again, as is normal Prison Service policy, he went back into healthcare pending a health assessment which was scheduled for the following day. After the assessment the man was discharged from healthcare and so returned to his normal wing cell.
23. As a life sentenced prisoner, the man could only be held at a prison suitable to meet the needs of his age and type of sentence. The most appropriate prison available for him at the time was Moorland. Five months after being sentenced he transferred there on 27 June 2006.
24. After arriving at Moorland and going through the normal reception procedures, the man was allocated to HB 3. The third prison officer worked on HB 3 and knew the man well. She told my investigator that the man was polite and respectful, adding that he did not cause any problems. The officer described the man as someone who was neither happy nor outgoing. During one of her conversations with the man, he told the officer that he was no longer with his girlfriend, but did not expand on this. This prison officer left HB 3 in January 2007 and did not meet the man again until he moved to HB 4 later in the year.

25. The fourth prison officer works in the prison's Offender Management Unit. He told my investigator that, between 14 March 2007 and 11 April, the man joined the Life Sentenced Prisoner Induction Group and apparently participated well.
26. However, at the end of March, the man complained to an officer that three prisoners were threatening him and taking his tobacco whenever he went to his workplace. In line with the prison's anti-bullying strategy, the man was interviewed by a wing manager the same day (30 March 2007). He told the manager that he did not know the names of the prisoners bullying him. After assessing the information and speaking to the man's workshop instructor, it was decided to change his place of work with immediate effect. He was re-employed in one of the prison's production workshops. The workshop is responsible for packing breakfast packs for the prison and its sister site, Moorland Open. The man was content with the outcome. He was advised to speak to staff if he had any further concerns and the file was then closed.
27. Unfortunately, on 22 July 2007, the man had cause to complain once again that he was being threatened for his tobacco. This time, the man told staff the names of the prisoners responsible. As with the previous event, the man was seen the same day by one of the wing managers. The manager's recommendation was for staff to monitor the man whenever he went to the prison shop, and for the two prisoners named by the man to be monitored and assessed. The file was closed two days later (24 July). As a result of the allegations, and to help the man, he moved from HB 3 to HB 4.
28. The third prison officer, who had previously known the man when he was on HB 3, met him again on HB 4. She told my investigator that the man was quieter than he had been on HB 3 and did not mix with other prisoners. The prison officer said he kept himself to himself, but was liked by other prisoners. She remembered how he would remind prison staff to unlock him so that he would not miss his education classes. This officer said there was never anything to suggest that the man was planning to harm himself.
29. A prison officer had recently taken over as the man's personal officer. Although he had not had the opportunity to meet the man formally, he described him as someone who blended in and did not bring attention to himself. The man's personal officer confirmed that he had no reason to be concerned about the man's safety.
30. In the meantime, the probation department was preparing an annual review of the man's life sentence plan. The man's probation officer met him for about one hour at the beginning of August 2007, after which she returned to her office to write her report, completing it on 17 August. The probation officer said the man was very polite, chirpy and motivated to change and address his offending behaviour. She said that the man told her that he deserved his sentence and accepted it, although he said he was not the person responsible for the victim's death. The probation officer said that the man did not appear suicidal.

31. My investigator met the Officer Instructor (OI) who is responsible for the breakfast pack production workshop where the man was employed. He described the man as polite and responsive, and said he would do what was asked of him. He added that the man was not a control problem and, as well as doing his own work, the man would assist him to clean the workshop. The officer instructor said the man always spent time with him at the end of the work period and they would chat about everyday issues, such as what was in the news. He said that, as well as the work he was doing in the workshop, the man was undertaking part time education classes designed to assist his reading and writing skills.
32. The officer Instructor said that on the day before he died (i.e. 21 August 2007), the man worked as normal in the workshop. The officer instructor told my investigator that he was planning to give the workshop an extra clean on the following Friday. The man was aware of this and asked him if he could assist, offering to scrub the floors, which the officer instructor agreed to. The officer instructor said that at no time did the man give any indication that he was planning to harm himself, nor did he ever say anything about being bullied. He last saw the man at 4.30pm, which was the end of the work period.
33. During the evening, prisoners are allowed out of their cells to associate with one another. The third prison officer remembered seeing the man that evening. She told my investigator that he was laughing and joking. With hindsight, she said this was out of character.
34. A prison officer was on duty in HB 4 that evening. He told my investigator that the man was a polite young man who caused no problems to wing staff. This prison officer said that during the evening the man had been mixing with other prisoners in the wing. At about 7.55pm, the evening association period came to an end and prisoners returned to their cells for the night.
35. The prison officer described how, once prisoners are locked into their cells, he carries out a roll check and accounts for all of the prisoners on his landing. He said that he looks into the cell through the observation panel in the cell door and satisfies himself that the prisoner is in the cell. Once he has accounted for all his prisoners he then goes to the wing office to enter the number on a lock up sheet and sign for his roll.
36. After the total wing rolls are collated and agree with the prison roll, the majority of staff on duty leave the prison. One officer remains behind in each Houseblock pending the arrival of the night staff who take over. The officer who remained in HB 4 that evening was another prison officer.
37. The second prison officer arrived for duty at about 8.00pm. He went to HB 4 and took over from the other officer. The second prison officer had arrived early for his night duty to enable the other officer to leave earlier than would otherwise be expected. Before leaving the Houseblock, the other officer handed over to the second prison officer, but did not pass anything on relating

to the man. Although not the night patrol for HB 4, the second prison officer assisted the Operation Support Grade (OSG) assigned to HB 4 by counting the roll.

38. The second prison officer told my investigator that in order to carry out a roll check he opens the door observation panel and looks for the prisoner. He said that he remembered seeing the man sitting on his bed watching television. The prison officer said the man was in a double cell, on his own and using the lower bunk. He told the investigator that neither he nor the man spoke to each other. The officer confirmed to the prison's communication room that his roll was correct.
39. A OSG arrived at the prison at about 8.15pm. She was allocated as the night patrol on HB 4. When she arrived onto HB 4 she spoke to the second officer who told her that the roll check had been completed.
40. My investigator asked the OSG if she had been given any specific instructions about the man, and she said not. As she had not been given any instructions to monitor the man outside the normal roll checks, there was no expectation that she would see him again until the next check scheduled to take place about 5.00am. Between them, the second prison officer and the OSG carried out the HB 4 patrol checks during the night. Other than a routine management check by the Senior Officer (SO), the night was uneventful.
41. The Senior officer started work at about 8.45pm. He was given a handover by the Orderly Officer who had been on duty during the day. The senior officer confirmed that he was not given any information relating to the man. He said he was given a list of the names of all prisoners who were being monitored under the Prison Service suicide and self harm support procedures, and confirmed that the man was not on the list.
42. The Senior officer said that at about 9.00pm he received confirmation from the communications room that the prison roll was correct. He said that for staff to confirm the roll, they have to get a response from the prisoner. Even if they are underneath a blanket, staff are required to see some movement.
43. During the night, the SO carried out his management checks and visited the Houseblocks. He confirmed at interview that he had been to HB 4 and completed his checks.

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44. When it came to the time to complete the morning roll check at 5.00am, the second prison officer and the OSG divided the Houseblock up between them and shared the work. The OSG went to the third landing, whilst the second Officer started at landing one. At interview, the OSG said that, in order to see into the cells at night, she has to switch on the light. That is what she did when she arrived at the man's cell and looked through the observation panel. When she looked into the cell she saw the man hanging from the light fitting. She described how he had a ligature around his neck. It had been fashioned

from a prison issue bed sheet. The OSG said the man was facing the bed. From her position, this was on the right hand side of the cell. She said his body looked lifeless, not moving and that his eyes were open. The OSG added that the man's head was tilted to the right, and his body fully suspended off the ground. The OSG remembered seeing a chair to one side of the man's body, but could not recall which side.

45. The OSG shouted to the second prison officer who was still on the lower landing. As he was running up the stairs, the OSG used her prison radio to request assistance by calling a "code blue" emergency.
46. The OSG removed the leather pouch containing a cell key from her belt and handed it to the prison officer. She said they waited for other assistance to arrive and, as soon as they had sufficient staff there, the cell door was unlocked. The second prison officer said that three prison officers arrived, along with the Healthcare Officer and the Night Orderly Officer, the senior officer. The OSG could not recall who opened the door, but believed it was the second officer. This officer confirmed that he took the pouch from the OSG. However, he had difficulty breaking the pouch seal and it was another Officer who managed to break it and remove the key. The cell was then unlocked and the officers went in.
47. The OSG said that when the cell was unlocked she stood outside the cell looking at the man. She heard one officer say he could tell from the man's appearance that he was dead. Another officer arrived and, seeing that the OSG was distressed, took her to an office.
48. My investigator asked the OSG if either she or the second prison officer had considered entering the cell. Although the OSG believed that the man was dead, she said they had not thought of entering as she understood that cells should not be entered unless three or four staff were present. The OSG could not recall who had given her this instruction, but it was something that she believed to be the case.
49. The second prison officer said staff were instructed not to enter a cell until other staff were present. He added that this was so the officers had witnesses if anything were to happen. My investigator asked him if he would have felt confident to enter the cell, and he confirmed that he would.
50. The second prison officer described at interview how two of the officers took the weight of the man's body, whilst he cut the ligature at the point it was connected to the light fitting. They then placed the man onto his back on the cell floor. The officer said the man's tongue was sticking out and was discoloured. His skin was blotchy and his body motionless. The second prison officer thought that the man's neck was broken. He recalled seeing a chair next to the man's body and believes he used it to stand on before hanging himself. The second officer said the Healthcare Officer told them that, out of respect for the man, she was not going to attempt resuscitation.

51. The second prison officer added that, soon after entering the cell, paramedics arrived. After carrying out their own checks, they confirmed that the man had died. The second prison officer asked one of the paramedics if they should have attempted resuscitation and was told that it would have been ineffective.
52. The Healthcare Officer (HCO) told my investigator that she did not know the man and had not met him prior to responding to the code blue call. At the time she received the call she was working in the prison's healthcare centre. The nurse was assisted by an OSG night patrol who was looking after 12 prisoners.
53. As soon as the code blue call was received, the HCO grabbed an emergency response bag containing the necessary equipment for someone experiencing breathing difficulties. The nurse told my investigator that the bag contains oxygen, mask, aspirator suction equipment, defibrillator, airways and an Ambu bag, which is used to push air into the patient.
54. The Healthcare Officer said that, after collecting the bag, it took her no longer than one and half minutes to arrive at the man's cell. When she arrived, she saw the three Officers cutting the man down and laying him on the floor. The Healthcare officer said it was obvious to her that the man had been dead for some time. She described his arms as mottling, his face as bloated and his tongue extremely swollen and blocking his airway. She checked for any respiratory signs but could not find any. She added that the man's body was cold to the touch.
55. My investigator asked the Healthcare officer if she had carried out Cardio Pulmonary Respiration (CPR) and was told not. She said that, due to the man's tongue being so swollen, she could not have performed CPR. The Healthcare Officer added that the officers did not perform CPR either, as they were still cutting him down when she arrived. She went on to say that, although she is not medically qualified to certify a death, her nursing experience allows her to verify that someone is dead. In the man's case she believed that it would have been inappropriate and undignified to start CPR.
56. The Healthcare Officer said she was still at the cell when paramedics arrived. She said they connected an Electrocardiograph (ECG) machine to the man's body. ECG equipment monitors the activity of the heart. Sadly it did not detect any signal and the man had died. The HCO said she spoke to the paramedics about CPR and they told her that they would not perform CPR. It was their opinion that the man had been dead between three to five hours.
57. The clinical review describes the man's condition as cyanosed (a blue tinge to the skin) with signs of mottling and being cold to the touch. The man's airway was obstructed by his tongue and no respiration or pulse was detectable.
58. Because of the nature of the man's death, the paramedics asked for the police to be called.

59. The Senior Officer was in his office when he heard that the OSG had asked for code blue medical assistance on HB 4. He described the office as being approximately 150 yards from the houseblock.
60. He said that, when he arrived at the cell followed by the Healthcare Officer, he saw a number of staff about to open the cell door. He added that he got to the cell just as the officers were opening the door. The Senior Officer saw the staff enter the cell and begin to cut the man down. He immediately contacted the communications room and asked for an ambulance, after which he went back to the cell. When he arrived at the cell, the Healthcare Officer had already decided that the man was dead and confirmed that CPR had not been carried out. The SO contacted the communications room and asked the operator to telephone the on call Duty Governor, and (in line with Prison Service instructions) the police. The Senior Officer said that paramedics arrived at about 5.45am, followed ten minutes later by police officers.
61. The Senior Officer followed the prison contingency plans and sealed the area where the man had died, treating it as a potential crime scene. Once the police had completed their enquiries, and were satisfied that the man did not die in suspicious circumstances, they released the cell back to the prison and allowed the man's body to be taken by undertakers to the mortuary.

After the man's death

62. Following the young man's death, his next of kin details were obtained from his prison record. The recorded address was some considerable distance from Moorland and, in order to inform his family at the earliest opportunity, the Duty Governor asked a manager at a prison more local to his mother's address to break the news on his behalf. Once the man's mother had been told, Moorland's own family liaison officer and a prison chaplain travelled to her home to offer condolences and to provide more information about what had happened.
63. In the meantime, prison management reviewed all prisoners who were being monitored under the Prison Service's suicide and self harm procedures. Additionally, Listeners were asked to assist staff by supporting prisoners who might be affected by the man's death.
64. The prison's care team was asked to support staff. In general, this appears to have worked well. However, one member of healthcare staff felt that the care team support had been less than satisfactory. In contrast, the OSG said the care team support was good. Unfortunately, she said she could not say the same about her support from prison management.
65. Following any death in custody, the Governor should follow the instructions contained in PSO 2710 and hold a de-brief meeting with those staff involved as soon as possible. The practice is known as a "hot de-brief". It would appear from the staff interviewed that this was not done following the man's death.

ISSUES

Clinical Review

66. The clinical review notes that the man's health and mental health needs were assessed appropriately during his time in prison. His healthcare needs were assessed and, when required, further investigation was carried out. A psychiatric review carried out at Moorland concluded that the man did not require any on-going supervision or treatment. There were no recorded changes in his mood, behaviour or emotional state that might have indicated a change in his healthcare. The reviewer is satisfied that the man's mental health assessments were properly managed.
67. She further notes that between June 2006 and August 2007 the man was treated in healthcare on just one occasion. The reason for seeing healthcare was that he complained of coughing, chest pain, vomiting blood and abdominal pain. An x-ray taken at the time was reportedly normal, with no other medical evidence found to explain his symptoms. The clinical review confirms that there were no documented reports in the man's medical record of any change in mood or emotional state.
68. As part of the clinical review, it was considered what type of medical equipment was available to the nurse. The clinical reviewer concludes that the appropriate medical equipment was quickly available.
69. The clinical reviewer recommends that prison staff should be commended for their support to the man, especially at the time of his trial, sentence and transfer to Moorland. Although I make no formal recommendation on this, the Governor may wish to share the views of the clinical reviewer with the Governor of Castington and his own staff.

Unlocking a cell at night

70. The OSG was not sure about the circumstances that would allow staff to enter a cell at night. She was accompanied at interview by her husband, who is also an OSG. He too was uncertain and told my investigator that he had asked Senior Officers for guidance, but had not been given a clear answer. He described it as a grey area. Clearly there is some confusion about unlocking a cell door at night. I am satisfied that the small delay in unlocking the man's cell made no difference whatsoever to the outcome. However, in another emergency, it might well have been vital to have entered the cell immediately and administered emergency aid if resuscitation was to have any effect. The Governor may wish to consider issuing guidance on entering cells at night.

Resuscitation

71. I am satisfied from the descriptions given by those staff who found the man that CPR was not possible. Like the healthcare nurse who attended the man

that morning, I believe that it would not have been decent or appropriate to have attempted resuscitation.

Staff support

72. At interview, the OSG, who at the time of her interview was off duty as a result of the man's death, said it was approximately seven days before anyone from a managerial position contacted her. She said her colleagues had supported her, as had the prison care team. However, she felt let down by management.

73. The Healthcare Officer said that she had been supported by her own colleagues. Although she did not wish to say anything on tape, she added that she felt let down by the local prison care team. I am not aware to what she was referring but the Governor may wish to review the arrangements for supporting staff.

Debrief

74. PSO 2710 explains that following a death in custody a hot de-brief should take place. It adds that a senior member of staff should lead the de-brief and a member of the care team must attend. It would appear from those staff interviewed that no hot de-brief was carried out.

The Governor should ensure that hot de-briefs are carried out in line with the instructions contained in PSO 2710.

Suicide and Self Harm monitoring

75. My investigator was impressed to see displayed at the entrance to the prison a notice board showing the names and location of all prisoners who were being monitored. The system is updated as necessary and tells all staff at a glance the current situation. I regard this as good practice.

CONCLUSIONS

76. This young man had a chaotic background. He had been convicted of murder and was serving a life sentence. At a minimum, he had no prospect of release until he was over thirty years old. Whether this had any bearing on his decision to end his life cannot be known, but it has to be a possibility.
77. A further possibility is the implied by the fact that he had complained of being bullied, with the most recent recorded event taking place approximately one month prior to his death. Whether this was actually a factor is once again unknowable. What I can say is that I am satisfied that prison staff treated what the man told them seriously and dealt with the complaints appropriately.
78. The man appeared to have settled well into Moorland. He had engaged with the education department, wanting to improve his key skills and would remind prison officers to unlock him so that he could go to his class. Only a few hours before he died, the man had planned with his instructor the arrangements for cleaning the workshop a few days later. Sadly, it seems certain he had other things on his mind that he did not share with anyone else.
79. I am satisfied that the man kept his true intentions close to his chest and that neither prisoners nor prison staff had any inclination about what it was he was planning to do. Additionally, I am satisfied that the systems were in place to support the man, had he shared his suicidal thoughts with staff.

RECOMMENDATION AND GOOD PRACTICE

The Governor should ensure that hot de-briefs are carried out in line with the instructions contained in PSO 2710.

The Governor has accepted the recommendation and intends to implement the change by 15 March 2008

The display board showing the names and locations of all prisoners being monitored for suicide or self harm is good practice. It informs every member of staff arriving for duty the name and location of those prisoners deemed to be vulnerable.

The Governor acknowledged the recognition of good practice and said the system has worked well.