Investigation into the circumstances surrounding the death of a man on 8 August 2004 at HMP Elmley

Prisons and Probation Ombudsman for England and Wales

July 2005

This is the report of an investigation into the circumstances surrounding the death of a man on 8 August at HMP Elmley. The investigation was carried out under the transitional arrangement for investigating deaths in custody agreed between my office and the Prison Service, and was conducted by the Head of Security and Operations, Dover Immigration Removal Centre.

The report deals with the management of the man during his time in the care of staff at HMP Standford Hill and HMP Elmley, and also the systems, procedures and staffing matters relevant to the care of prisoners who are potentially vulnerable to suicide or self-harm. It also examines the circumstances surrounding the decision to transfer the man from Standford Hill to Elmley.

The Senior Investigation Officer was assisted by the Principal Officer at HMP Swaleside, and specialist medical input was received from a doctor of the Swale Primary Care Trust. I am grateful to them all for their work.

Together with the investigation team, I would like to offer my sincere condolences to the man's family and partner and would like to thank his parents for their assistance in providing background information.

I would also like to thank the Governors of Elmley and Standford Hill for making the necessary arrangements to accommodate the investigation team. Additionally, I am grateful to the Principal Officer for his assistance with the investigation and the Senior Officer who acted as the investigation's Liaison Officer.

I conclude that the man's death could not have been predicted or, for that reason, prevented. What was in his mind must forever remain a mystery. I am, however, concerned by what this investigation has revealed about alcohol and drug abuse at Standford Hill over the weekend of 7/8 August 2004.

The report makes 12 recommendations for Standford Hill and one for Elmley, and identifies two examples of good practice.

Stephen Shaw CBE **July 2005**
Prisons and Probation Ombudsman

Contents

SUMMARY

1. The man had been in custody for a period of 32 days before his death on 8 August 2004. He had previously served a 28 day sentence for drink driving in December 1997 at HMP Belmarsh.

2. On 29 July 2004, he was transferred to open conditions at HMP Standford Hill from HMP Elmley after his initial classification as a convicted prisoner.

3. Whilst in prison, the man had participated in two medical healthcare reception screens in July and August 2004 – one on initial reception into Elmley and another on initial reception into Standford Hill. His health screen at Elmley revealed that he had been treated for depression three weeks before his sentence but highlighted no cause for concern. He did not inform staff at this stage of any previous attempt to take his own life and no immediate risks were perceived.

4. Throughout his time at Standford Hill, the man made many telephone calls to his partner which generally suggested that he was coping with his sentence. However, during a number of the calls there were strong suggestions that he was involved in alcohol and drug misuse. This was later confirmed by another prisoner, located on the same landing, who admitted to the investigation team that they were both misusing cocaine and cannabis.

5. At Standford Hill, the man's healthcare reception screen revealed that he had informed staff about a previous attempt to overdose. Documentation from the reception screen states that an attempted overdose took place in January 2004 with written comments stating 'no problems now'. No immediate risk was perceived and no further action was taken regarding these comments.

6. The day before his death, he received a visit from his father, partner and brother. They did not feel that he was at risk but stated that throughout the visit he talked about how other prisoners were bringing drugs in through visits.

7. The weekend of 7/8 August 2004 was very hot and there were large groups of prisoners consuming alcohol and taking drugs, which resulted in a number of incidents throughout Sunday 8 August 2004.

8. During the evening of Saturday 7 August, the man participated in a party in one of the cells on his landing. He had a quantity of cannabis and a gram of cocaine that he and two other prisoners took. It is not known who supplied him with the drugs.

9. On 8 August at 12.03pm, he telephoned his partner and stated that he was going to leave the prison and that 'he had had enough'. It is believed that he left the prison just after this call. He telephoned his brother and was picked up by him and a friend who took him to a local caravan site which they knew. Whilst at the caravan site, his brother persuaded him to return to prison and

after a few drinks dropped him off at the back gate leading to the prison boundary.

10. At approximately 4.55pm, the camera operator noticed the car stop at the gate and staff were deployed to search the area where they found the man returning to prison. Although staff smelt alcohol on his breath he was not slurring or swaying. He informed them that he had absconded that day, but was persuaded to return by his family. He then became upset and changed his version of events saying that he left the establishment because he had been forced to pick-up heroin by another prisoner and that he would get his throat cut if he did not return with it.

11. The man was taken to reception, where the Orderly Officer interviewed him. Shortly afterwards, he was asked to show staff where the heroin was hidden. He was returned to the area but pointed to a different position than that he had originally identified and refused to answer any questions that were put to him. Staff could not find any evidence to suggest drugs had been left, and felt that he was possibly fabricating the story in order to reduce the severity of the penalty he believed he would receive for leaving the prison.

12. He was again returned to reception while the Orderly Officer organised his transfer to HMP Elmley. Whilst waiting in reception, he went into the toilet area and broke out of a window. He was seen running towards HMP Swaleside and the nearby housing estate.

13. Staff searched the area and eventually found the man hiding in a shed in a garden. When challenged by staff, he came out of the shed and walked back to Standford Hill.

14. On arrival at the gate, a number of visitors and prisoners were returning from town visits. The man started to goad staff and they felt that he was 'playing to the crowd'. The Orderly Officer made the decision to transfer him immediately to Elmley.

15. At approximately 6.55pm, he arrived at HMP Elmley with no documentation or property. He had become quiet and staff reported that he seemed to have calmed down.

16. The Orderly Officer at HMP Elmley was concerned that the man had arrived at the prison without his core record (F2050) or Inmate Medical Record (IMR), he had a cut to his wrist, and staff had reported that they believed he had been drinking alcohol. Because the prison was on patrol state and he needed medical treatment, he was taken straight to Healthcare for treatment and assessment. Patrol state is the term used by the Prison Service to describe periods when prisoners are locked in their cells, staffing levels are at a minimum, and there is at least one officer patrolling the area.

17. After the first steri-strip was placed on his wrist he became very agitated and refused all treatment. The nurse attempted to undertake a risk assessment

of him but he said no to all questions and was using foul and abusive language.

18. After all attempts to undertake his cell share risk assessment failed, the man was taken to the Segregation Unit pending his adjudication the following day.

19. After locating him in his cell, the Orderly Officer telephoned the Duty Governor and relayed his concerns that the man had arrived with no documentation and seemed to have been under the influence of alcohol. The Duty Governor then instructed that the man be transferred to the Healthcare Centre for closer observation throughout the night.

20. At approximately 8.00pm, staff observed the man lying on his bed with a blanket over his head. He sat up when staff looked through the observation panel. The Orderly Officer organised a member of staff to get a 'smokers pack' from reception whilst they waited for Healthcare to finish settling another of their patients. At approximately 8.20pm, staff entered the cell with the intention of giving him a cigarette before moving him to the Healthcare Centre.

21. He was found kneeling forward on the floor with his laces tied around his neck attached to the table. On the wall, by the head of the bed were written the words "I love you D".

22. Staff attempted to resuscitate him until the ambulance service arrived at the scene. They were not successful.

23. Contingency Plans were appropriately followed in response to his death.

24. The investigation team could find no evidence to suggest that the man was being pressurised by other prisoners, other than the one comment he made on returning to prison. In the short time he was in custody, he had never suggested to staff or behaved in a way that suggested he was unable to cope with his sentence or that he wanted to end his life. He was not on an open F2052SH care plan and had never been on one throughout his sentence.

25. The toxicology report confirms that he had a quantity of cocaine and alcohol in his blood on the day he died. The investigation team conclude that this may have created the mood swings that he displayed throughout the day. It is also possible that the mixture of drugs and alcohol in his system may have affected his ability to think through his predicament clearly, and thus resulted in his tragic death.

26. There are a number of recommendations arising from the man's death and the investigation of procedures at Standford Hill and Elmley.

HMP ELMLEY

27. HMP Elmley is a large local prison serving the courts of Kent. During weekend evenings, the prison is in patrol state with prisoners locked in their cells and reception closed. Staffing levels at this time consist of two Senior Officers, 11 Officers, two Healthcare workers and four OSGs. The establishment has 24 hour nursing cover with an in-patient facility.

28. The segregation roll on the evening of the 8 August 2004 was 17. There were four prisoners under rule 53, six prisoners held under Good Order or Discipline and seven prisoners held under cellular confinement.

29. The Independent Monitoring Board's (IMB's) Annual Report for 2003, states that *"the board was satisfied that generally Elmley is a safe environment for prisoners, staff and visitors. The board was pleased to see improvement in resettlement work and hope that this continued"*. The report goes on to say that, *"the segregation unit functions very well and the staff are always co-operative when dealing with segregation issues".*

30. The investigation team informally interviewed the Chairperson of the IMB who attended the prison on the night of 8 August. She commented that she was impressed with the level of professionalism shown by staff and the outside agencies that attended the segregation unit. She also stated that she believed that, on a daily basis, level of care in the segregation unit was first class and Elmley was improving all the time.

31. The last HMCIP visit to Elmley was an unannounced follow-up inspection on 12-14 May 2003. In summary, the subsequent report said, *"Elmley had improved considerably from the last inspection with many of the previous recommendations implemented; relationships between prisoners and staff in the segregation unit were good and in general, prisoners spent relatively little time in the unit and segregation was not used excessively".*

32. There had been two deaths at Elmley in the previous 12 months: on 2 November 2003 and 16 March 2004.

HMP STANDFORD HILL

33. HMP Standford Hill is an open training establishment holding category D prisoners. Prisoners progress through the system and have the opportunity of working in the community on a voluntary and paid basis prior to release. At the weekend, a high number of prisoners are released on temporary licence for town visits. There is no full-time medical cover. Healthcare is closed after 5.00pm every day.

34. On Sunday 8 August 2004, the prison unlock roll was 446. There was a total of 49 discharges through reception that day. With the exception of two hospital escorts, all prisoners were due to return between 6.30pm and 7.45pm.

35. Staffing levels throughout the day at weekends consisted of three Senior Officers, 10 Officers and two OSGs. These were in place on the day in question.

36. The prison boundary consists mostly of small fences and bushes. There are cameras placed along the main road leading up to the prison but there are many areas where prisoners can easily breach the boundary without being seen.

37. Prisoners are issued with their own room key and are not accounted for when going on or off the accommodation units. At weekends, the regime allows prisoners freedom of movement throughout the day except for a short time at roll checks.

38. The prison roll checks at weekends are at 7.45am, 11.40am, 6.00pm and 8.45pm. At these times, prisoners are expected to be in their rooms and remain inside throughout the roll check.

39. The Investigation team informally interviewed the Chairperson of the IMB. He stated that the IMB team felt that Standford Hill was a safe place for prisoners. He commented that he had regularly sat in on prisoner induction talks given by wing Senior Officers and they gave very clear guidelines on Bullying, Diversity and Care Issues. A Prisoner Information Booklet regarding the Anti-Bullying Strategy is given to all prisoners during Induction.

40. Minutes from the Anti-Bullying Committee bi-Monthly meeting do not highlight a large problem with bullying at Standford Hill. There had been just four bullying incident forms submitted in both June and July and no investigations were needed into unexplained injuries to prisoners.

41. On 5 August 2004, Her Majesty's Inspector of Prisons carried out an unannounced inspection and reported that *"Standford Hill had a good suicide and anti-bullying system* and that *staff engaged more readily with prisoners, including personal officers.* The report also said *reception and induction procedures had improved".*

42. There have been no deaths at HMP Standford Hill in the last 12 months**.**

43. The following self-audit results are specific to this investigation:

Date	Percentage Achieved	Audit	Re-audit Date	Percentage Achieved
14.06.04	68%	Discharge Procedures	29.7.04	Compliant
22.12.03	78%	Prisoner Induction	12.5.04	Compliant
20.02.04	66%	Safer Establishment	1.9.04	Compliant

INVESTIGATION PROCESS

44. The team received the terms of reference and began the investigation process on 19 August 2004 under the Prisons and Probation Ombudsman's Standing Commission.

45. In the first instance, the Governor of Elmley, Deputy Governor and Governor of Standford Hill were consulted. Members of the POA Committee and IMB were also informed at both Standford Hill and Elmley.

46. The Segregation Unit at Elmley where the man died was visited twice, along with four visits to B wing at Standford Hill where he was located prior to transfer back to Elmley.

47. The Detective Inspector handling the enquiry was consulted, along with two prisoners located at Standford Hill who knew him.

48. All the relevant paperwork relating to his situation, care at Standford Hill and Elmley and the general operation of both prisons, was examined.

49. A clinical audit was requested by the investigation team after consulting his IMR. The clinical audit was conducted by the Swale PCT.

50. Additional reports, including the last IMB Annual Report, the relevant HM Chief Inspector's report, the last Standards Audit report for Elmley and last Self Audits at Standford Hill, Contingency plans, Security Committee meeting monthly report, Anti-bullying Policy and Monthly Committee meeting minutes, and recommendations into the last deaths at Elmley, were examined.

51. The team met once with the man's parents. Telephone calls between 31 July and 8 August that he made were listened to. Fourteen staff were interviewed.

INCIDENTS AND EVENTS LEADING UP TO THE DEATH OF THE MAN

52. On arrival at HMP Elmley after sentencing, the man's Prisoner Escort Record (PER) and the reception screening and cell share risk assessments undertaken by reception and healthcare highlighted no cause for concern. He was recommended a 'single cell if available due to sleepwalking, talking and outbursts'. His cell share risk assessment was assessed as medium because of this, with no immediate risk perceived.

53. The man was seen by the healthcare staff on his arrival at Elmley. His first reception health screen was undertaken on the day of arrival. He stated that he had seen a psychiatrist for depression and was previously prescribed 20mg Cipramil. This drug is usually prescribed for depression and panic attacks. He did not inform staff of the previous attempt to end his life and all information on the health screen indicated no reason to see a doctor. The entry in his IMR reads *"seen on reception, history of mild depression was on Cipramil, nil at present, feels okay, no self-harm issues"*.

54. The initial induction form completed by reception and induction staff with the man also raised no cause for concern. Again, he was asked if he had a history of self-harm or if he had thoughts of harming himself and in both cases stated no. Again no risk was perceived.

55. He was allocated to cell A1/12 on House block 1 which is the induction wing. He completed a full induction programme with no recorded concerns.

56. On 15 July 2004, the man's initial categorisation was completed and he was categorised as a D category prisoner and allocated to Standford Hill. On 29 July, he was transferred to Standford Hill.

57. On arrival at Standford Hill, he was allocated to B wing cell 2-003. His healthcare screening took place on the same day. This suggests that he informed the staff that he had taken an overdose in January 2004 with the entry stating *"no problems now".* The doctor signed the reception healthcare screen on 30 July. No further comments were recorded and he was not seen as at risk.

58. All new prisoners to Standford Hill undertake an induction programme on A wing. Within this period, the Education, Chaplaincy and Gymnasium staff saw the man. No concerns were raised at this time and on 3 August he was allocated work on the gardens.

59. His telephone conversations suggest that he was settling in well to the regime and the work particularly as the weather was good over the period.

60. A Resettlement Assessment, which took place whilst at Standford Hill, suggests that he had discussed his previous attempted suicide with staff. The form states *"attempted suicide by taking tablets in July 2003 – over it now. Did suffer from depression and drank a lot".*

61. It is usual practice for new prisoners to be informed of their Personal Officer on arrival onto their designated wing. However, the man's Personal Officer was on annual leave over the period of 29 July-8 August, and there was no designated relief Personal Officer assigned for the landing he was on, due to a member of staff gaining temporary promotion. During this 11 day period, it is unlikely that he was interviewed at any length by a member of the wing staff. However, the Governor said *"all prisoners are interviewed by the Senior Officer responsible for the Induction programme and given the opportunity to discuss any issues of concern"*.

62. The prison has devised a policy "Understanding the Personal Officer Scheme", which is an information guide to staff explaining the Personal Officer work that should be undertaken by staff. Unfortunately, the last Governor's Order published was in August 2002, which listed Personal Officers and their responsible landings. This had numerous gaps in the staffing list, which resulted in no named Personal Officers in some of the residential areas. Whilst conducting the investigation the team was pleased to note that this had been rectified on one of the wings, i.e. B wing.

    The Governor should review the Personal Officer scheme to ensure that all prisoners are allocated a Personal Officer, along with a named relief, on arrival at HMP Standford Hill.

63. Throughout the man's time at Standford Hill he made numerous telephone calls each day to his partner and also one to his brother.

64. Whilst talking to his partner, he came across as coping well and generally quite happy. In one call he mentions talking to the *"vicar about marriage and divorce"* and their future together. In some of his conversations he seems to suggest that he had been involved in drink and drugs parties whilst at Standford Hill. In one conversation, shortly after he arrived at Standford Hill, he said *"I'm staying away from everyone from now on".* He also said that *"he was reformed and trying to keep away from it"* but, goes on to say *"mind you, there were six sitting in my cell last night and I'm trying to think, how do I get out of here…"*

65. On Thursday 5 August 2004, the man phoned his partner. During this conversation he states, *"everyone's getting out, it's hard when I can't phone you. If I've spoken to you, I'm OK, but if you weren't there I'd probably upset everyone and I'd be back over the road by now"* (referring to returning to Elmley). These are the first comments that suggest he might have been struggling to cope. However, he seemed to quickly get over this and talked about a newspaper article he had been sent regarding his court case. Some of his last comments on that day were that he was *"staying away from all druggies and shutting his door".*

66. During the weekend of 7 and 8 August, the weather was hot and it is now known that there were prisoners drinking alcohol and taking drugs in the grounds of the prison. It is unknown if he had participated in any of the parties throughout the day on Saturday 7 August. Due to his visit, it is

assumed that he only participated in one in the evening. Drinking continued throughout the wing on the Sunday.

67. On Saturday 7 August the man's partner, brother and father visited him in the afternoon. His father stated that throughout the visit his son was pointing out how other prisoners were getting drugs through visits and that the staff were not monitoring the visit session.

68. After the visit at 4.15pm, he phoned his partner and thanked her for visiting and asked her to *"come up the next week on her own".* He ended the call by saying that he loved her.

69. At 5.28pm, the man telephoned her again. They talked about him having a party, he said *"it's just surviving that's all it is in here".*

70. At 8.06pm, he phoned her yet again and talked about missing her and really appreciating everything that she had done for him. He went on to say, *"you mean more to me; this is just a bad time".*

71. The man again talked about going to a party in No 10 (cell 10), and said *"I'm going to gate crash them and will be running home to you tonight so if you get a reverse charge call".* That night he is said by a prisoner to have had a gram of cocaine and some cannabis that he shared with two other prisoners. It is unknown where he got the drugs from, but one of the prisoners involved in the party that night stated that he did not believe that the man was in debt to anyone for the drugs they were using.

72. On Sunday 8 August at 11.58am, he phoned his partner to say that he had just got out of bed and that he would give her a ring tonight.

73. At 12.03pm, the man telephoned her again, and said *"are you coming up here today".* She replied *"No"*. He then said *"I'll be leaving here in a bit".* She asked *"why?"* He said *"I've had enough now".* She asked *"when are you going to phone?"* He said, *"When do you want me to phone?"* She said *"just let me know"*. He said, *"I'll reverse the charges".* He then asked *"where is my friend - in the caravan?"* She confirmed this. He asked her if she loved him, she said *"yes"* and he ended the call by saying that he would ring her later. This is his last recorded call made at Standford Hill.

74. Another prisoner who had been with the man at Elmley, stated that since he had arrived at Standford Hill he talked most days about absconding and always seemed to have a lot on his mind. He believed that the man had mentioned that his brother was staying at a local caravan site and that he had been in touch with him throughout most of the week and had asked him to pick him up. Other prisoners suggested that he was smoking cannabis and taking cocaine on a regular basis. They stated that drugs were quite easy to get hold of in Standford Hill and they got the impression that he wanted his brother to bring him in alcohol and pick him up. No other prisoners who the investigation team talked to thought that he was being pressurised or owed money to others for drugs.

75. On Sunday 8 August, the man was seen at the lunch time roll check by another prisoner. There were a number of incidents on the man's wing that staff had to deal with throughout the day, and it is believed that these were the result of prisoners drinking alcohol and taking drugs throughout the weekend.

76. The first incident of the day was at approximately 3.51pm when the Fire Alarm was raised between rooms 33 to 48. All prisoners on the wing were evacuated. The Fire Brigade arrived, checked the wing, declared the alarm false and left the prison at approximately 4.20pm. Staff believed that a prisoner set the fire alarm off, as a way of calling staff to the area. Whilst the SO (Oscar 2) was controlling the evacuation of the wing, a prisoner came out of the wing with a serious cut to his hand. First aid treatment was given and the prisoner was then issued with a temporary licence and taken by an OSG to the local hospital for treatment. The prisoner stated that he had slipped while walking along the landing and cut his hand with a cup he had been holding. Security information collated later suggests that the cut may have been the result of a fight over drugs or alcohol.

77. At 4.55pm, a car was seen by the camera operator alongside the LAS Gate on the boundary of the prison. This is a well-known 'drop off' point for drink and drugs and staff attention was drawn to the cameras as the car stopped. The camera operator became suspicious when he noticed a man, later identified as the one who died, get out of the car.

78. A member of staff was directed to the area. At the same time, the OSG was returning from the local hospital after dropping off the prisoner with the cut to his hand and was also alerted to the fact that a car had stopped in the 'drop off' area. When the driver of the car saw the OSG pull up behind him, he drove off. This is now believed to have been the man's friend and brother who had persuaded him to return to the prison.

79. At 5.05pm, the man was found by staff near the entrance to the LAS Gate. He seemed calm at first. When asked if he had anything, he handed over four new packets of Old Holborn tobacco and a number of letters and photographs to the staff. He explained that he had planned to abscond but his family had persuaded him to return to prison.

80. Staff felt that the man was telling the truth due to the fact that he was returning to prison with his letters and photographs (these are items that prisoners normally take with them when they plan to abscond). However, he suddenly became 'jumpy' and told the staff that he was under pressure to bring drugs into the establishment. He was asked if he had any drugs on him to which he replied no, but pointed to a spot about ten yards away near some conifers. At this point, he became tearful and continued to say that he was under pressure to bring drugs into the prison. Staff decided to take him to the reception area where the Orderly Officer was waiting.

81. The SO asked the OSG to sit with the man and give him a cup of tea while she made arrangements for his transfer back to Elmley and closed conditions. Throughout the 15 minutes the OSG was with him, he talked about his family and where he lived. The OSG sensed an underlying agitation in his voice when he mentioned that he did not want anything to do with drugs, that there were drugs in the prison and that he wanted to get away from it. He asked the OSG if he would be returning to Elmley. The OSG did not confirm this, but believed that the man assumed he would be returning to closed conditions because he said *"well, I'll be going down the road".*

82. The man continued to talk about drugs in the establishment and asked *"did the staff know where they were".* However, the OSG felt that he was not in a position to talk to him about security information and therefore told him to tell the Senior Officer when she returned.

83. The SO then interviewed the man. The SO reported that he stated he had left the establishment after the fire alarm at 3.51pm. However, another prisoner believed he left the prison after the roll check, which corresponded to him phoning his partner for the last time at 12.03pm. The SO did not make a note of the interview at the time, and only made notes later in the evening after his death. The investigation team felt that, as a consequence, her timings could have been wrong.

84. The man described to the SO how he had been sent out to pick-up heroin from a tree and that if he did not return with it he would get his throat cut.

85. At approximately 6.00pm, the SO and staff took him back to the area where he told them the drugs were waiting. He pointed to a different place in a different direction from where he had initially showed staff. After a search of the area was conducted, no drugs or parcels were found and he then refused to cooperate and remained silent. Staff came to the conclusion that, because he had returned with his letters, and could not identify the pick-up point that he had earlier described, he was fabricating the story.

86. The man told the SO that his friends had picked him up, taken him to the roundabout and back, and that he had been out of the establishment for half an hour. Again, this did not correspond with suggestions made by other prisoners who said that they believed he had intended to abscond as he had been in touch with his brother regularly, had talked about absconding every day, and was finding it difficult to settle into his sentence.

87. His parents were able to corroborate his initial statement on the events of that day by confirming that his brother was doing some work on a caravan at one of the local caravan sites. The man phoned his friend and asked to be picked up. His friend then phoned his brother and they picked him up, took him to the local caravan site, brought him a couple of drinks and persuaded him to return to prison.

88. Because the man had stated that he was in danger if he returned without the heroin, and as he was a high risk of further abscond as he had already absconded and returned, the SO made the decision to transfer him back to Elmley. At this point, he was left in the reception waiting area, locked behind a gate, whilst the SO made arrangements with Elmley.

89. The holding area within reception has a smaller area which can be partitioned off by a secure gate where prisoners can be held. Within the gated area there is a toilet. This is not secure as there is a window with no bars that leads to the back of the reception building.

90. At approximately 6.10pm, he smashed the toilet window and was seen by staff running towards Swaleside. An urgent message was put over the radio net and staff responded to search for him.

91. The Orderly Officer and staff searched the area around the housing estate located opposite the prison. He was not found, so the SO instructed a member of staff to go back for the prison van as she felt he might have started to make his way across the fields that lead to the main road.

92. The SO, two officers and an OSG proceeded along the main road. They travelled approximately two miles before they satisfied themselves that he was not crossing the fields.

93. On returning to the prison, the staff split up and continued to search for him. Whilst the staff were searching around the houses opposite the prison, one of the residents informed them that they had seen him in one of the gardens.

94. At approximately 6.35pm, the SO and an officer found him hiding in a shed. He complied with the request to come out of the shed and, although he looked dishevelled, walked back to the prison with no problems. Staff noticed that he had cut his arm, which they assumed happened whilst breaking through the window. He later confirmed this when the nurse at Elmley tried to treat the wound.

95. On the approach to the prison, there were a number of prisoners and visitors waiting outside the gate after returning from community visits.

96. Staff state that, when the man saw the other prisoners, he seemed to 'play to the crowd' and became quite verbally agitated towards the staff, making reference to the fact that staff had had to chase him twice that day and that *"he wasn't very good at getting caught twice".* None of the staff involved in the recapture felt that he was at an elevated risk of self-harm or that he seemed depressed.

97. Because he had just been recaptured, and there was no secure area to hold him, and there were numerous prisoners waiting around the gate area to be processed after returning from community visits, the SO made the decision to transfer him immediately to HMP Elmley.

98. None of the man's records or property accompanied him and there was no written handover, F213, PER form or re-categorisation form highlighting the circumstances of his transfer. He was neither informed verbally nor in writing of the reason for his transfer.

The Governor should remind staff that the IMR and F2050 must accompany all prisoners on transfer.

99. A Senior Officer and two staff escorted him to Elmley using the prison van. Throughout the journey, staff report that he was quiet and said nothing.

100. At 6.57pm, the man arrived at Elmley reception and was met by the Orderly Officer. He seemed calm and joked that he had given staff the run around and escaped from them twice. Elmley staff noticed that he had a glazed expression and smelt of alcohol but was not acting as if he was drunk.

101. Because of the cut to his arm, and the fact that there were no accompanying records or handover notes, he was immediately taken to Healthcare to be treated. The Orderly Officer insisted that Standford Hill staff accompanied him to Healthcare before returning to their own establishment.

102. The on duty Healthcare worker was an agency nurse. He asked the Standford Hill Senior Officer in charge of the escort for the man's medical record. She contacted the Orderly Officer at Standford Hill and passed on the request. However, neither the IMR nor core record arrived until after his death. The investigation team later found out that there is no written policy for gathering core records including the IMR in the event of an 'out of hours' transfer, and that staff at Standford Hill feel the system for gaining access to prisoners' records and warrants is very time-consuming. In this case, no effort was immediately made to gather the information for Elmley and later in the evening another fight between prisoners at Standford Hill further delayed the record gathering.

103. The agency nurse attempted to dress the man's cut arm. After the first steri-strip was placed on the man's arm, his behaviour changed and he told the nurse to get away from him and that he didn't want further treatment. When the nurse tried to persuade him to continue with the treatment, he became agitated and said, *"do you think I am HIV or something, I have been married for 13 years".*

104. The agency nurse then tried to conduct the reception healthcare risk assessment, however the man refused to comply. Every time he was asked a question, he answered using foul and abusive language.

105. The agency nurse felt that the man's behaviour did not warrant any special medical care and he was quite safe to go to the Segregation Unit and be placed in a single cell pending his adjudication for absconding.

106. The man fully complied with a strip-search, but threw his clothes around and needed to be told to calm down. The only other conversation that he had

with staff at Elmley was when he asked if they had a cigarette and told them he *"didn't want to talk to anyone but wanted to sleep".*

107. At approximately 7.30pm, he was taken to the Segregation Unit.

108. After locating the man in the Segregation Unit, the Orderly Officer contacted the Duty Governor raising his concerns that the man had arrived at the establishment with no documentation, that he had broken out of reception at Standford Hill, and that his mood swings suggested he might have been drinking. The Duty Governor instructed that he be placed in Healthcare for the night for closer observation.

109. The Orderly Officer informed Healthcare that the man would be transferred to them overnight. The agency nurse requested clarification from the Duty Governor on this decision, as he had completed the algorithm which assesses healthcare concerns as showing no risk.

110. The Duty Governor phoned back to Healthcare in order to confirm his instruction to locate the man there for the night.

The Duty Governor should be commended for the care shown by him to the man.

111. At approximately 8.00pm staff checked on the man. He was lying with a blanket over his head, which prisoners often do to block out the light and noise. He sat up when the observation panel was opened.

112. As he had previously asked for a cigarette, and none had accompanied him from Standford Hill, staff went to reception to get a 'smoker's pack' with the intention of supplying him with a cigarette before his relocation to Healthcare.

113. At approximately 8.20pm, the Orderly Officer and staff entered his cell with the intention of transferring him to the Healthcare for the night. He was found kneeling in the cell with a ligature round his neck made from his shoelaces, which was attached to the table. He was slumped forward on his shins.

POST-INCIDENT RESPONSE

114. The Orderly Officer immediately entered the cell and cut the shoelaces with the 'fish' scissors he was carrying. An urgent message for Healthcare to attend the scene was relayed. The second healthcare worker on duty attended very quickly and started CPR with the assistance of the Orderly Officer.

115. Staff recall seeing that, on arrival in the cell, the man's face was blue and there was no pulse. The agency nurse was called to attend with the heart start machine. He was able to attend quickly as the night healthcare staff had arrived for duty. The agency nurse took over CPR from the Orderly Officer.

116. On placing the defibrillator on the man, the machine found no rhythm in him and staff continued CPR until the paramedics arrived.

117. At approximately 8.50pm, the paramedics arrived and continued to attempt to resuscitate him, but they announced life extinct at 8.52pm.

118. At approximately 10.10pm, the doctor arrived and certified the man was dead.

119. After the SO had stopped assisting with CPR, he noticed written on the wall of the cell, close to where the man would have lain, the words *"I love you D"* which had been written in what looked like blood.

120. The Duty Governor returned to the prison very quickly. He arrived before the ambulance crew. The assist Orderly Officer (Oscar 2) had arrived at the scene with the second healthcare worker and had already started a log of those entering the man's cell. The Duty Governor commenced actions as stated in the contingency plans.

121. After the ambulance crew had declared the man's life extinct, all staff left the cell and the area was sealed.

122. The IMB Chair was contacted and attended the Segregation Unit along with the Chaplain who is also a member of Elmley's care team. Other prisoners located in Segregation were cared for and assessed for any heightened risk of self-harm or suicide. One prisoner who was due to transfer the following day was admitted to Healthcare for closer observations during the night.

123. During the Chair's informal interview, she reported how impressed she was with the respect shown to the man whilst the different agencies were going about their work.

124. The Duty Governor contacted Standford Hill's Duty Governor who had also been called to his establishment and was dealing with an incident. This was a nasty assault involving two prisoners that resulted in hospital treatment.

Security intelligence gathered later revealed that the assault was believed to be over drugs and alcohol.

125. At approximately 10.00pm, the man's F2050 (Core record) arrived from Standford Hill. At approximately 10.35pm, the Police arrived at the prison. At 11.50pm, the Coroner's representative and SOCO arrived at the scene. At 2.20am, the undertaker took the man from the prison and the cell was resealed.

126. Incident forms were completed by staff involved and staff interviewed by the police.

127. The man had named his brother as his next of kin. The Duty Governor arranged for the Chaplain to represent the prison and inform his brother personally of the tragic news.

128. At approximately 4.00am, the Chaplain arrived at his brother's house in Forest Hill and broke the news of the man's death. The Chaplain offered support and to be with the brother when telling the rest of the family, however this offer was declined.

129. Staff involved in the incident were given a 'hot' debrief before leaving the establishment, and a full debrief took place the following day.

130. On Monday 9 August, the man's father telephoned the prison and spoke to the Duty Governor. He was invited to attend the prison; however, this was declined by the family and a follow-up letter was written by the Governor on 12 August offering condolences and support.

131. His father had to attend at both Standford Hill and Elmley to collect his personal possessions. The majority of his property was still at Standford Hill.

132. On collecting his property, his father was distressed to find that the man's stereo, items of clothing and some money were believed to be missing. One member of staff cleared his property from his room at Standford Hill.

133. The Head of Security informed the man's father that he would make enquires to try to recover his son's stereo. However, the only evidence the investigation team could find of an attempt to locate the property was an entry in the Wing Observation Book, although the Governor later said that staff were briefed on the importance of recovering the radio. During the investigation team's enquiries, his stereo was returned to the team by another prisoner who claimed he had brought the stereo from him before he absconded. The team also found that his private cash and earnings had transferred to HMP Elmley and had not been returned to his family after his death.

134. On Monday 9 August, a full lock down search of B wing at Standford Hill found evidence of 11 bottles that were likely to have previously contained alcohol and a number of weapons. This, along with security intelligence,

confirmed that there were a high number of prisoners consuming alcohol throughout the weekend. A small number of prisoners, suspected of being involved, were transferred back to Elmley.

135. The toxicology report confirms that the man had traces of alcohol and cocaine in his blood on the day he died.

LEVEL OF COMPLIANCE WITH PROCEDURES AT STANDFORD HILL

136. The investigation team studied three sets of minutes from Security Committee meetings between the months of May to July. Attendance was good and statistics showed concerns had been raised over the high number of drug and alcohol finds throughout each month. However, the minutes did not contain any evidence to suggest that monthly security objectives had been set for the establishment.

The Governor should set regular monthly security objectives to address concerns raised at the monthly Security Committee meetings.

137. The following Self-Audits were examined: Prisoner Induction, Discharge Procedures and Safer Establishments. All documentation suggested that the systems were found to be compliant and the audits had no outstanding action points.

138. The last Standards Audit Unit audit took place in December 2002. All action points had been completed and this suggested a compliant prison. However, staff at Standford Hill believed that prisoners transferred out of hours often went without their IMR, which would have been forwarded later. One manager at Elmley recalled an incident, only a few weeks after the man's death, where a prisoner who had returned from abscond and had reported to Standford Hill to be told to walk down the road and 'give himself up' at Elmley rather than Standford Hill. The prisoner did as instructed and reported to the gate at Elmley without any documentation or identification. His documentation had to be forwarded to Elmley from Standford Hill later.

The Governor should develop a protocol for transferring prisoners out of hours from open to closed conditions, along with clear guidance.

139. Minutes from the Monthly Suicide Prevention meeting were studied. Out of the 11 members on the committee, five regularly did not attend. F2052SH documents that were opened within the month were discussed but there were no statistics to identify any trends. Between January 2004 and December 2004 only seven F2052Sh forms were opened, which probably explains the lack of statistical information available.

The Governor should address the lack of attendance at the Suicide Prevention and Anti-Bullying meetings. The monitoring of F2052SHs should be a standard agenda item.

140. The investigation team studied the staff training records of those involved in the incident and found that there had been a lack of training in Suicide Prevention. Two out of the three Senior Officers on duty that day had never received training in suicide prevention and the Orderly Officer had not had any training since 2001. Out of three of the officers involved in the incident, one had never received training, one in 1998 and the other in 2000. The only person who had received training within a reasonable timescale was the

OSG driver who last participated in training in May 2002. Staff training was not part of the agenda for the Suicide Prevention Committee meeting.

The Governor should address Suicide Awareness Training. Suicide prevention training should be a standard agenda item for the Suicide Prevention meeting.

141. The Use of Contingency Plan 'in the event of an Abscond or Recapture' was not used by the Orderly Officer when the man returned to Standford Hill, or after he absconded from the establishment for the second time.

142. The Orderly Officer stated that she had no knowledge of the Contingency Plans for Standford Hill and her actions were based on experience. On studying the plan for absconds, the investigation team felt that it gave very little guidance on actions to be taken and the protocol when sending prisoners back to closed conditions. The plan does not meet the requirements set in PSO 1400 and had not been reviewed since 2003.

The Governor should review the procedure for the management of incidents and ensure that all managers undertake training in incident management. The Governor should also ensure that the contingency plans comply with PSO 1400 and that all managers are familiar with the local contingency plans.

143. Incidents were generally not recorded on an incident log and the only entries that were made were in a book that the centre officer/controller uses to account for the roll.

144. The IMB highlighted to the investigation team that they were not informed of the events of the 8 August 2004 until the following morning. Guidance on who to inform when an incident occurs was not included in the contingency plan along with contact with the care team. The procedure for reporting the incident via the Incident Reporting System was correctly followed.

The Governor should ensure that the Abscond Contingency Plans are updated to include contacting a member of the IMB and Care Team.

145. A debrief for staff was held the following day. However, there was not a list of those staff in attendance and the investigation team was unable to confirm if staff were able to put forward their concerns or suggestions.

146. The contingency plans were not reviewed after the incident.

147. Minutes of the Anti-Bullying meeting were examined for February to August 2004. The meetings seem irregularly attended with only the Chair and Security PO attending the August meeting. Eight out of the 19 members attended the June meeting and four attended the February meeting. The investigation team note that there had been an improvement with the statistics and in identifying trends over the last couple of meetings since a different manager had been made responsible for the policy.

LEVEL OF COMPLIANCE WITH PROCEDURES AT HMP ELMLEY

148. The investigation team studied the Contingency Plan for Death in Custody and the Staff Debrief notes. These were found to be compliant with PSO 1400.

149. When the man was found with a ligature around his neck, staff responded quickly and professionally and all evidence was preserved. The DS informed the team that she could not fault the systems adopted by staff to preserve the evidence. The care team fulfilled their role of supporting staff and prisoners and managers ensured that all prisoners located in the Segregation Unit were seen directly after the incident. The Duty Governor returned to the prison quickly and ensured that correct procedures were in place.

150. HMP Elmley has a Suicide Prevention Policy Document, a Suicide and Self-Harm Prevention Strategy Document, a Know your Job sheet giving staff guidance on Opening, Monitoring and Closing F2052SHs and an Operational Order reference the Management of Prisoners 'at risk' of suicide and self-harm. All are comprehensive documents that have been reviewed within the recommended timescale. The team found that staff were aware of these documents and had a good understanding of the F2052SH care plan procedures.

151. The investigation team studied the minutes from the last two Safer Prisons meetings. Membership included a prison Listener and meetings held bi-monthly. Points were actioned and, from the minutes, there seemed to be no major concerns.

152. Training records for staff involved in the incident were studied and it was found that those involved had been trained in Suicide Prevention in 2001. The agency nurse had not had any local training. He has a professional qualification as a Mental Health Nurse.

153. In May 2003, there was an unannounced follow-up Inspection by HMCIP. Comments from the report suggest that Elmley had put into effect many of the recommendations that had been raised in their previous visit. These comments reflect the findings of the investigation team.

154. The investigation team have considered the recommendations from the two deaths in custody of November 2003 and in March 2004. All recommendations seem to have been addressed.

155. Minutes of the last two meetings of the IMB were studied along with their Annual Report for 2003. The minutes raise no major causes for concern and overall the Board is happy with Elmley's progress and development.

FINDINGS

156. There was no F2052SH opened on the man during his time at Standford Hill or Elmley. He appeared to be low risk and able to cope with his sentence. His telephone calls to his partner suggested that he was settling in well at Standford Hill and often included conversations that suggested he was looking to the future.

157. His healthcare reception risk assessments undertaken at both Elmley and Standford Hill were completed within the timescales set. At Elmley, he did not admit that he had previously attempted to take his own life and was not highlighted as being at risk. Twice at Standford Hill he talked about a previous attempt to overdose, which was prior to his previous sentence. However, he gave two conflicting dates for the attempt. The resettlement assessment stated he attempted suicide by taking tablets in July 2003, the Healthcare reception assessment stated overdose in January 2004. Both assessments did not perceive there to be an immediate risk.

158. The investigation team could not find any evidence to conclude that the man was being bullied or pressured into bringing drugs back into Standford Hill. However, the freedom of an open prison seemed to present too much of a temptation for him. Throughout his time at Standford Hill, he regularly talked to his friends about absconding from the establishment.

159. His behaviour during his short time in prison did not cause any concern for staff. His friends in prison seemed very shocked by his death and described him as a nice guy who regretted his offence and always seemed to have a lot of things on his mind.

160. The man was at Standford Hill for approximately ten days. He undertook a period of induction. However, he did not have the opportunity of being introduced to his Personal Officer due to annual leave and there was no ‘relief’ Personal Officer designated for the landing he was on.

161. The investigation team was unable to locate his wing history sheet, which suggests that one had not been started.

162. It has been established from his telephone calls that he was involved in a party in one of the cells on the Friday night. Security intelligence gathered after the weekend records that another ‘party’ took place outside in the grounds on the Saturday and continued in the evening on the wing. Prisoners and staff later reported that the fights and injuries during the Sunday were the result of prisoners consuming alcohol and possibly selling drugs.

163. The man’s friends in prison stated that he regularly took cocaine and cannabis whilst at Standford Hill.

164. He would have remained unlawfully at large had his brother and friend not persuaded him to return to continue with his sentence.

165. Upon returning to Standford Hill the first time, he seemed unsure as to what would happen to him. The interview undertaken by the Orderly Officer concentrated on trying to ascertain where drugs were being dropped off and where they were held in the establishment. At the point that the Orderly Officer told him he would not be returning to his room, no consideration was given to explaining to him what would happen to him. He was not informed in writing as to the reason for his transfer.

166. The Orderly Officer investigated the man's comments that he was sent out to collect drugs; however, this was not documented or shared with the Elmley staff.

167. No consideration was given to the fact that he became upset and might have been at risk after being caught returning to prison. The fact that he had been upset earlier was not documented or shared with the Elmley staff.

168. Although on recapture he seemed to have mood swings, staff reported that they did not feel threatened by him. They felt that he was uncooperative rather than displaying aggression.

169. The property (quantity of tobacco and letters) that were confiscated from the man on initial recapture, were not forwarded with him when he was transferred to Elmley.

170. There was no attempt by the Orderly Officer to gather his official documentation or his property to accompany him on transfer. During informal interviews, staff reported that prisoners had transferred without documentation and IMRs before and this was a regular practice.

171. The man had absconded from Stanford Hill and was facing an adjudication. Given that Elmley received no other information about him, the decision to place him in the Segregation Unit cannot be criticised.

In relation to safer custody issues at HMP Standford Hill

172. Between Friday 6 and Sunday 8 August 2004, it seems there were many prisoners consuming alcohol in Standford Hill. On 8 August, the day the man died, there were a number of incidents. These included a fire alarm and a prisoner found with a cut to the hand that required hospital treatment. Additionally, there was a prisoner who was dehydrated due to the hot weather and was suspected of consuming alcohol. Security intelligence later suggested that the cut hand was the result of a fight over drugs. A full lock down search the following day revealed a number of empty bottles containing alcohol.

    The Governor of Standford Hill should review the events at Standford Hill over the weekend of 7/8 August 2004.

173. There is no secure holding area at Standford Hill that can be used to hold prisoners who challenge the regime or those who are vulnerable. This has an impact on the decisions managers make when considering returning prisoners to closed conditions. The only area that can be segregated from others is a part of reception, which has a gate but no bars on the toilet window. This leads directly into the communications room and is in full view of prisoners who are in reception.

The Governor should consider submitting a bid for funding to facilitate a secure holding area

174. The Orderly Officer left the prison throughout the evening in order to search for the man. Throughout this time (approximately 25 minutes) the establishment did not have an Orderly Officer to respond to any further incidents and the reduction of staff resulted in no tea time roll taking place.

The Governor should remind Orderly Officers that they should not leave the prison whilst the prison is unlocked.

175. Because the man had already absconded from the reception holding area, and there was a large number of prisoners waiting outside reception on return from town visits, the Orderly Officer felt that it was appropriate for the man to be immediately transferred to Elmley. The decision to transfer him without his core record, warrant, PER form, medical record, re-categorisation form, F213 or adjudication paperwork was not a decision that the team would expect from a manager with experience who had been placed in charge of the establishment.

176. No written statements were made by the Orderly Officer on the incidents of the day. It was only after management were made aware of his death that evening that they wrote incident notebooks on the events earlier in the day.

177. The man's cell was sealed until a member of staff was able to clear his property. At least two members of staff should have carried out this task. Very few items were recovered from the cell and, when his father collected the property on 12 August, he reported that a radio and various other items were missing. The Duty Governor who met with the father stated that he would attempt to locate the missing property and placed an entry in B wing's observation book. Apart from this entry, very little effort was made in attempting to find the missing property. When the investigation team spoke to his parents, they were clearly distressed that they had not received all his property or money and suggested that the prison had deliberately kept it.

The Governor should ensure that at least two members of staff carry out the cell clearance procedure.

The Governor should ensure that the instructions contained in PSO 2710 "Follow-up to deaths in custody" are followed.

178. During an informal interview undertaken by the investigation team with prisoners who had found the man's stereo, they suggested that he might have sold the property to other prisoners prior to leaving the prison. Friends suggested that it was unlikely that he had any debts through buying drugs as they believed he had his own supply chain from outside the establishment.

179. No entries were placed in B wing observation book regarding him absconding or the other incidents that took place on 8 August, until 12 August when an entry was made and backdated.

CONCLUSIONS

180. There was no evidence in the man's behaviour whilst in prison to suggest that he was at risk.

181. The investigation team has been unable to establish his level of involvement in the drug culture at Standford Hill. From the toxicology report and comments from his friends, we can establish that he consumed alcohol and took cocaine and cannabis on a regular basis. However, there is no evidence to suggest that he had been put under pressure to return to Stanford Hill with heroin. The investigation team feel it is possible that he may have said he was in personal danger hoping he would be dealt with more leniently on his return.

182. If there had been a secure room away from other prisoners where the man could have been located, staff might have been able to take stock of the situation, monitor and properly interview him, collate the appropriate records and documentation and collect his personal property before transfer.

183. The Orderly Officer made the right decision to transfer him back to closed conditions. However, she made no telephone contact with the Duty Governor to seek his authorisation for the transfer and relied on the radio operator to carry out the requirements of the contingency plans. She also did not understand the importance of ensuring documentation and information was passed on to Elmley.

184. On enquiring into the whereabouts of the man's property and private cash, the investigation team found that his money had been transferred to Elmley on 9 August and had not been collated in order to return it to his parents. A member of the Senior Management Team should have taken ownership of this task. One officer instead of the usual two cleared his property from his cell.

185. The team was unable to ascertain if the man had sold his stereo, but have concluded that it would have been unlikely that any other prisoner had gained access to his property after his death. When friends were asked if he had sold his stereo to repay any debts he had due to buying drugs, they stated that it was unlikely as they believed he had his own supply chain from outside the establishment. This has not been corroborated.

186. On commencement of the investigation, Standford Hill management was unaware of the location of some of the man's records. Parts had been sent to Elmley the day after his death and some remained at Standford Hill. This resulted in an unnecessary delay in the completion of the investigation whilst the documents were located.

187. It would have greatly assisted the investigation team if a member of Standford Hill staff had been appointed to gather all the records, paperwork, possessions and valuables and if these had been kept in one location. A

Liaison Officer had been appointed, however he did not meet with the team throughout their time at Standford Hill.

RECOMMENDATIONS

HMP Standford Hill

1. The Governor should review the Personal Officer scheme to ensure that all prisoners are allocated a Personal Officer, along with a named relief on arrival at HMP Standford Hill.

2. The Governor should remind staff that the IMR and F2052 must accompany all prisoners on transfer.

3. The Governor should set regular monthly security objectives to address concerns raised at the monthly Security Committee meetings.

4. The Governor should develop a protocol for transferring prisoners out of hours to closed conditions, along with clear guidance.

5. The Governor should address the lack of attendance at the Suicide Prevention and Anti-Bullying meetings. The monitoring of F2052SHs should be a standard agenda item at the Suicide Prevention meetings.

6. The Governor should address Suicide Awareness Training. Suicide Prevention training should be a standard agenda item for the Suicide Prevention meeting.

7. The Governor should review the procedure for the management of incidents and ensure that all managers undertake training in incident management. The Governor should also ensure that the contingency plans comply with PSO 1400 and that all managers are familiar with the local contingency plans.

8. The Governor should ensure that the Abscond Contingency Plans are updated to include contacting a member of the IMB and Care Team.

9. The Governor should consider submitting a bid for funding to facilitate a secure holding area.

10. The Governor should remind Orderly Officers that they should not leave the prison whilst the prison is unlocked.

10. The Governor should ensure that at least two members of staff carry out the cell clearance procedure.

11. The Governor should ensure that the instructions contained in PSO 2710 “Follow-up to deaths in custody” are followed.

12. The Governor of Standford Hill should review the events at Standford Hill over the weekend of 7/8 August 2004.

HMP Elmley

1. The Duty Governor should be commended for the care shown by him to the man.

2. The Orderly Officer should be praised for bringing to the attention of the Duty Governor the fact that no documentation arrived with the man.

GOOD PRACTICE

There is an F2052SH information sheet located at the gate at HMP Elmley which names those prisoners who are subject to a F2052SH care plan.

The preservation of evidence procedures at HMP Elmley are a further example of good practice.

GLOSSARY OF TERMS

CPR	Pertaining to Chest (Heart and Lung) resuscitation
F 2050	Prisoner's Main Core Record
F2052SH	At Risk of Self Harm Record
F213	Injury Report Form
F2169	First Reception Health Screening Form
Gov	Governor (Senior Managers) Graded A-F
HMP	Her Majesty's Prison
IMB	Independent Monitoring Board
IMR	Inmate Medical Record
LIDS	Local Inmate Database System (computer)
Offr	Officer
PO	Principal Officer
POA	Prison Officers' Association
Remand	Prisoner held in custody before conviction
SO	Senior Officer
Standard Audit	Prison Service Internal Audit System
Fish Scissors	Scissors that are carried by staff and which are designed to cut down someone who has attempted to hang themselves
Smokers Pack	Quantity of tobacco and papers issued to prisoners on arrival into reception.

INQUISITION

The inquest into the man's death took place between 19 February and 9 March 2007. The jury found that the man died as a result of 1a suspension and that he took his own life. At the request of the family solicitor and with the permission of the coroner, I have included the jury's verdict, comments and the Coroners' Rule 43 report.

The jury were asked to consider a number of questions, which I have listed along with their answers:

1. During the man's time in prison up to the day before his death was the information available to prison staff in relation to any potential risk to his life dealt with appropriately?

   The jury said not, adding that certain procedures were not carried out by prison staff regarding the healthcare forms.

2. On the day of his death, were any potential risks to his life adequately appreciated by staff at Standford Hill and Elmley?

   Yes

3. Were appropriate steps taken that day regarding his safety by staff at (a) Standford Hill, (b) Elmley?

   (a) No, due to lack of documentation. (b) Yes.

4. Did the staff who had dealings with the man have adequate training (1) and experience (2) to enable them to identify, assess, communicate and address any potential risks to his life?

   (1) Inadequate training for healthcare staff with regard to prison procedures and documentation. (2) Yes.

5. Were the actual staffing levels sufficient so as to ensure that the man was adequately supervised and cared for at (a) Standford Hill, (b) Elmley.

   (a) No, due to exceptional circumstances on the day. (b) Staffing levels appeared inadequate in the Elmley healthcare department.

6. Could any further steps have been taken by prison staff which might have avoided the man's death?

   Yes, failure to transfer correct documentation and inadequate verbal communication on handover from Standford Hill to Elmley. More frequent observations by prison officers in the segregation unit at Elmley may have avoided the man's death. And due to the nature of the transfer a prison governor should have been consulted before the man was transferred from healthcare to the segregation unit.

7. If you consider any of the following matters to be of significance to the circumstances of the man's death, please comment on them: (a) whether or not the man had taken cocaine, either on the day of his death or the day before; (b) whether or not the man had been threatened; (c) whether or not the man left the prison to bring drugs in. Please comment on any other factual matters relating to events on the weekend of the man's death, if you consider them to be of significance to the circumstances of his death.

   (a) Yes, the man taking cocaine was a contributing factor to his death. (b) No, due to lack of a secure holding area at Standford Hill, transfer procedures were not carried out correctly.

   A combination of cocaine and alcohol was of significance to the circumstances of the man's death

On 13 March 2007 the Coroner wrote to the Director General of the Prison Service under the terms of Rule 43. The report included the jury verdict and questionnaire. Additionally, the Coroner made the following five points:

1. The national First Reception Health Screen form F2169 (in use as at July 2004) provides for a mandatory referral by a healthcare worker for a mental health assessment if the answer to question 8,9 or 10 is positive (past mental health treatment or medication or self harm). Guidance could be considered to assist healthcare workers on the correct procedure where they assess that there is no current concern regarding the prisoner's mental health.

2. Guidance could be considered to supplement PSO 1700 to assist nurses and doctors in how to complete the Segregation Unit Safety Algorithm where the prisoner does not co-operate at the interview.

3. A protocol could be considered between HMP Standford Hill and Elmley covering the circumstances, if any, in which it is permissible to transfer a prisoner without his Inmate Medical Record (IMR) and a requirement in any such circumstances for escort staff to hand over specified information (written and/or verbal).

4. The provision of a facility could be considered for the temporary detention at HMP Standford Hill in a secure location for a prisoner awaiting transfer while his IMR is collected because out of hours a healthcare worker has to be brought in to arrange this.

5. It could be considered whether there is a link between the consumption of alcohol and an enhanced risk of self harm.

The Coroner ended his letter adding that he would copy the letter to Her Majesty's Chief Inspector of Prisons and asked for it to be distributed to local management.