Investigation into the circumstances surrounding the death of a man at HMP Grendon in September 2009

Report by the Prisons and Probation Ombudsman for England and Wales

August 2010

This is the report of an investigation into the death of a man. He was found hanging in his cell at HMP Grendon in September 2009. He was a life sentenced prisoner, having been convicted of the manslaughter of his partner in 2000. He was 47 years of age.

I extend my condolences to those who knew the man and I hope that my report goes some way to answering their questions. I apologise for the delay in completing this report.

The man's death is the first to have occurred at HMP Grendon since the Ombudsman started investigating deaths in custody in April 2004. I understand that the previous self inflicted death at the prison was 16 years ago.

The investigation into the death was undertaken by an investigator. A clinical review was conducted by a clinical reviewer on behalf of the local Primary Care Trust (PCT). I am grateful to him and his review is annexed to this report. I would also like to take this opportunity to thank all of the staff and the Governor at Grendon for their cooperation with the investigation.

The man had a history of harming himself. He refused food on several occasions in protest as he had been in prison for longer than his tariff and had been unsuccessful in his bid for parole. He moved 19 times in the ten years that he was in custody, a number of which were at his own request. He appears never to have settled at any one establishment, frequently asking to be transferred to other prisons as soon as he got to a new prison.

On his transfer to Grendon the man appeared to settle, but quickly became disillusioned, refusing to participate in the therapy that the prison had to offer. Alerting staff that he was not eating, firstly because of constipation and then to avoid returning to HMP Rye Hill, staff opened Assessment, Care in Custody and Teamwork (ACCT) monitoring and opened a food refusal form. However, he started to eat again the evening before his death. I make a number of recommendations in my report relating to the emergency response by staff when they discovered him.

During his time in prison custody the man had a well documented history of harming himself, history of food refusal and masking his true feelings. I believe that staff at Grendon were not fully aware of the turmoil that he was suffering and his state of mind at the end of September 2009.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Jane Webb
Acting Prisons and Probation Ombudsman **August 2010**

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SUMMARY

The man, who had a history of suicide and of harming himself, was remanded in custody in December 1999. In June 2001, he transferred to HMP Grendon. However, having been considered unsuitable for its therapeutic regime, he transferred back to HMP Wormwood Scrubs.

Over the following years the man transferred prisons a number of times before arriving at HMP Buckley Hall in January 2006. Staff opened an Assessment, Care in Custody and Teamwork (ACCT) document as he had written to a friend that he wanted to end his life, as he believed he would never be released from prison. (The ACCT system is used to assess, observe and support prisoners at risk of harming themselves.)

Between 2006 and August 2008, the man made many applications to transfer prisons, some of which were successful. However, he appears not to have settled in these prisons and, either due to his own request or as a consequence of his behaviour, was transferred a further six times before arriving at HMP Rye Hill on 5 August. During this time staff opened two more ACCTs due to threats he made against himself and instances of food refusal.

The man appears to have settled quickly at Rye Hill. He complied with the prisons rules and regimes and, having got a job, told staff that he was happy having something constructive to do. However, in early November, he alleged that he had been bullied by another prisoner on the wing. He asked for no action to be taken and declined to move to another unit. He made no further complaints about bullying whilst he was at Rye Hill.

In May 2009, the man requested a transfer back to Grendon, saying that he felt he would benefit enormously from its therapeutic regime. On 20 July, he was accepted as being suitable for Grendon and arrived there on 28 July. During his induction he told staff that he had previously attempted to commit suicide, and had gone on hunger strike as he felt sorry for himself and saw other prisoners released on parole before him.

During his first weeks at Grendon, the man attended the prison's community group sessions, partaking in therapeutic discussions. However, by the middle of August, he began to withdraw from the meetings, at first by not actively participating and latterly by not attending. On 4 September, he expressed a wish to return to Rye Hill. His behaviour deteriorated and, on 14 September, he was sacked from his cleaning job.

On 20 September, the man complained to a nurse that he could not eat due to constipation and, as a consequence, had been giving his meals away for the previous eight days. The nurse contacted wing staff and asked them to observe whether or not he was giving his food away.

Later that day, due to his request to withdraw from therapy and his behaviour, the man was told that he would be returning to Rye Hill. Another prisoner described him as ambivalent about returning as he wanted to leave Grendon but believed that he

did not want to return there. He thought something concerned him about going back.

The following day, 24 September, the man was seen by a psychiatric nurse, having told a student nurse earlier in the day that he was depressed, frustrated and wanted to end his life by refusing food. The psychiatric nurse noted his eloquence in his desire to refuse food as a means of taking his life. In addition to notifying wing staff, the nurse referred him to be reviewed by a member of the mental health in reach team (MHIRT) the following morning.

Wing staff immediately opened the ACCT procedures and various support plans, including one from healthcare, were put in place. Staff started a food refusal form to monitor whether the man ate the meals provided. The following morning, 25 September, he was assessed by a member of the MHIRT. The nurse noted that he said he "had had enough", citing his harsh treatment and the unfairness of the prison system as triggers for his food refusal. However, he also told the nurse that he was too scared to deliberately harm himself.

The man refused his lunch that day but was seen eating his meal that evening, as well as taking a quantity of biscuits back to his cell. He was checked as required in his ACCT document. It was during one of these routine checks at 1.40am that he was found in his cell, having tied a ligature around his neck. Staff went into the cell to assist him. However, he was pronounced dead soon afterwards.

My investigator established that the man received good care whilst he was in custody at Grendon. However, some concerns are highlighted in my report about the way staff dealt with the emergency. In particular, with regard to entering his cell when he was discovered hanging and calling an ambulance. Although I am satisfied that these issues had no direct impact on his death, they highlight a number of areas in which improvements could be made to the emergency response.

THE INVESTIGATION PROCESS

1. The investigation into the circumstances of the man's death was carried out by one of my investigators. He opened the investigation on 2 October 2009 when he visited HMP Grendon. He met the Governor of Grendon, the Head of Therapeutic Services, and the Head of Residence. He also met two members from the Prison Officers' Association and a member of the Independent Monitoring Board. (IMB members are independent and unpaid. They monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained.)

2. Notices announcing the investigation and its terms of reference were issued to both staff and prisoners at Grendon. The notices were displayed around the prison and invited staff and prisoners to contact the investigator should they wish to do so.

3. My investigator was shown the cell and wing where the man spent the last weeks of his life. He reviewed the man's prison and health records and other documentation relating to the time that he spent at Grendon. He also visited the prison on several occasions to carry out interviews with staff and prisoners. My investigator was assisted by another of my investigators when interviewing staff. During the course of the investigation my investigator provided verbal and written feedback to the Governor.

4. My investigator also had access to transcripts of telephone calls made by the man to a friend. (The content of these telephone calls were not known to staff before his death. Only a small percentage of telephone calls made by prisoners are monitored. When calls are monitored they are usually for reasons of security or child protection. He did not fall into these categories.)

5. My investigators also spoke with a member of the therapeutic community, of which the man was a member. Although no other members of the community came forward individually to speak with the investigators, some did speak with the Senior Officer (SO), who kindly liaised on the investigators' behalf.

6. An independent clinical review was undertaken on behalf of the local PCT by the clinical reviewer.

7. My investigators spoke with a Detective Constable from Thames Valley Constabulary, who is acting on behalf of the coroner. My investigator has also been in contact with the coroner's office and a copy of this report will be sent to Her Majesty's Coroner for Buckinghamshire to assist his enquiries. A copy of this report will also be sent to the National Offender Management Service, the organisation that oversees the Prison Service.

8. One of the Ombudsman's family liaison officers contacted the man's next of kin, a friend of his, to discuss the scope of the investigation and give him the opportunity to raise any questions or concerns about the man's death. He asked why he served so long in prison and was not released on parole. I hope that this report helps address his concerns and any other issues that remain unclear,

helping him to better understand what happened in the time leading to his friend's death.

In response to the issuing of the draft report the man's friend raised a number of issues and concerns. These included that annexing the clinical reviewer's clinical review, and not incorporating its contents in the report, was a distressing omission. How it was that the clinical reviewer observed that the 19 times that the man was transferred between prisons were largely un-documented, but that the Ombudsman's report states that these moves were made at his own request. That information was not sought from the man's Member of Parliament to whom he complained about his difficulties at Rye Hill in 2008. Difficulties in relaying his concerns to the prison authorities after visiting him in September 2009 and why he had not progressed towards release having served his three and a half year tariff. The man's friend also questions the professional confidence of some staff and whether the man received satisfactory care whilst in custody.

Although I have addressed a number of these concerns in my report, one of my family liaison officers has addressed the remaining concerns raised by the man's friend in separate correspondence.

HMP GRENDON

9. HMP Grendon is a Prison Service Democratic Therapeutic Community or therapeutic community (TC) for short. Grendon is the only prison in the country to be run entirely on therapeutic principles and accepts some of the most challenging and disruptive men in the prison system. The regime offers prisoners (or 'community members' as they are known), the opportunity to address their offending behaviour and other related problems. Grendon's aim is to help them reduce their offending in order to lead more positive lives. As much responsibility as possible is given to community members who are in turn encouraged to take personal responsibility for their actions.

10. Community members at Grendon meet up to three times a week to discuss offending behaviour and manage domestic and regulatory matters related to living together. Staff are expected to support the TC in democratic decision making and to role model pro-social behaviour. Additionally both staff and TC members challenge and provide feedback about anti-social behaviour. Members are encouraged to practice new ways of behaving and deal with their problems more effectively.

11. Before prisoners can be accepted as full members of the TC, they are required to undergo an induction assessment to establish whether or not they are suitable for the regime and its therapies. Even before being considered for assessment, prisoners are made fully aware that, should they not be accepted at Grendon or decide to leave, they will return to the prison from which they came.

12. At the time of the man's death the Induction and Assessment Unit had been temporarily relocated to G wing while F wing, its normal location, was being renovated. During the induction, prisoners attend community meetings for an hour and a quarter each Monday and Friday morning. The meetings are also attended by officers and other staff including psychologists, chaplains and educationalists, if they are available. Smaller group meetings are held each Wednesday and an additional meeting is held on Thursdays when unit business is discussed. Official minutes of the meeting are not kept, due to reasons of confidentiality. However, general observations are recorded about individual prisoners by wing staff.

13. Primary healthcare at Grendon is provided by the local PCT with the mental in reach being commissioned from the Mental Health Trust. There is no 24 hour nursing cover.

14. The last full inspection of Grendon by Her Majesty's Chief Inspector of Prisons was an unannounced short follow-up inspection between 31 October and 2 November 2006. She reported that overall Grendon was:

> "… an impressive prison which does remarkable work with some of the most challenging prisoners in the system … the health and importance of the prison is not in doubt."

15. In 2006, research from Oxford University was commissioned, as a consequence of a recommendation made by HM Chief Inspector, to explain the disproportionately low rates of suicide and self harm. The incidence of self harm at Grendon in the period 2005-06 was only 29 per thousand prisoners, compared with 133 per thousand in the remainder of the male prison estate in 2005. The report concluded that there was evidence that the therapy programme offered by Grendon reduced prisoners' feelings of hopelessness and encouraged optimism about the future.

16. The Assessment, Care in Custody and Teamwork (ACCT) process operates in all prisons and aims to monitor and support prisoners who are assessed as at risk of suicide or self harm. Once an ACCT is opened, the prisoner is observed at pre-determined intervals according to their perceived level of risk. ACCT review meetings take place and the prisoner's progress and risk is reviewed by a multi-disciplinary team of staff who know the prisoner or are involved in their care.

17. The man's death was the first apparently self-inflicted death in Grendon since the Ombudsman took on the responsibility for the investigation of deaths in custody in April 2004. I understand that it is the first apparent self inflicted death to have occurred at the prison for 16 years.

KEY EVENTS

18. The man was 47 years old when he died. He had a history of assault and had received custodial sentences as a consequence. He also had a history of self harming. In 1988 he cut his wrists and in 1990 he was hospitalised for four days after taking an overdose.

19. On 24 December 1999, the man was remanded into custody at HMP Exeter, having been charged with the murder of his partner. He was subsequently sentenced to life imprisonment on 22 June 2000. His tariff, the minimum amount of time that he was required to serve before being considered for release by the Parole Board, was three years and six months. His first Parole Board hearing, in August 2003, recommended that he remain in closed conditions. At his second review in March 2006, the Secretary of State considered that he should remain in closed conditions, although the Parole Board had recommended a transfer to open conditions.

20. The man was transferred to HMP Wormwood Scrubs on 1 August 2000. On 19 June 2001, he was transferred to Grendon. However, he was not accepted as suitable for Grendon's therapeutic regime and, on 31 August, he transferred back to Wormwood Scrubs. Between October 2001 and January 2006, he was moved a further four times within the prison estate before his arrival at HMP Buckley Hall on 16 January 2006.

21. The same day staff at Buckley Hall opened an Assessment, Care in Custody and Teamwork (ACCT) document because the man had written, to a friend about his intention to end his life once he had worked out "… the best way of doing it". (This was the first time that he had been subject to ACCT procedures.) He told staff said that he believed he would never be released from prison, as other prisoners given life sentences at the same time had already been released on parole. He remained under closer supervision under ACCT procedures for the following five weeks. Having reassured staff that he had no further thoughts of harming himself, the ACCT procedures were closed on 24 February.

22. The man was transferred from Buckley Hall to HMP Coldingley on 5 June 2007, and onwards to HMP Highpoint on 19 June. Although applying for an immediate transfer on his arrival at Highpoint on 12 July, he told staff that he now wished to stay at the prison. However, on 22 July, he changed his mind and asked to transfer to HMP Wayland. He told staff that Highpoint was making him depressed due to less freedom and poor food.

23. The man made further applications for transfer to Coldingley and Buckley Hall in order to receive physiotherapy for an on-going back complaint, which he said he could not get at Highpoint. He was briefly moved to HMP Norwich on 23 November, as a consequence of an administration error regarding a transfer to Wayland. However, he returned to Highpoint five days later and remained there until 14 February 2008. He continued to complain about the treatment he was receiving from healthcare for his back problems. He applied for another transfer, this time to HMP Ashwell, where he believed the healthcare would be better.

24. On 30 November 2007, frustrated at the delay transferring to Wayland, the man became aggressive and smashed a television set in his cell. He told staff that he had tried to strangle himself the previous day and intended to starve himself to death. Staff immediately opened an ACCT. He said that his sentence was "becoming a nightmare", that he would die in prison and would one day succeed in ending his life early. He was for the second time monitored under the ACCT procedures. He received, amongst other support, input from members of the MHIRT. Over the following weeks his mood improved and, having stated to staff that he was eating normally and had no further thoughts of harming himself, the ACCT document was closed on 10 December.

25. The man began to repeat his concerns and frustrations about moving to Wayland on 6 January 2008. He walked out of a psychology interview the following day, saying he wanted nothing to do with Highpoint. On 8 January, he again told staff that he had not eaten for several days, saying the food at Highpoint was terrible and he could not eat it as the prison had the worst hygiene he had ever seen. Healthcare staff were informed of his food refusal and monitoring procedures were put in place. On 10 January, he was told that his request to transfer to Wayland was being considered and the situation would be helped if he started eating again. He explained that he had not eaten much because he did not like the food, but would make the effort to eat regularly.

26. On 22 January, the Parole Board wrote to the man confirming his request for a deferral in his hearing, which had been due to take place in March 2008, because of his transfer to Wayland. The Board advised him that his next hearing would be in September.

27. The man was transferred to Wayland on 14 February. However, by 16 March, his behaviour at the prison had deteriorated significantly. He ripped a wooden barrier from the wall of an office and barricaded his cell. As a consequence of his actions, he was moved to the prison's segregation unit.

28. During an interview on 1 April, the man told staff that he was feeling down and had thought about hanging himself the previous evening. He said that he had not eaten for two days and talked negatively about the future, saying that he would rather kill himself than spend the rest of his life in prison. Officers immediately opened the ACCT procedures and he remained under supervision until he was assessed as being no longer at risk of harming himself. The ACCT document was closed on 18 April. However, on 21 April, it was reopened when he was found in his cell having cut his wrists and telling staff that he had been talking to his dead sister. Once again he remained under observation on an open ACCT. By 19 May, he was assessed as stable, chatty to staff, in good spirits and displaying a normal pattern of behaviour. As a consequence of his continued improvement the ACCT document was closed.

29. The man continued to express his wish to be transferred and, on 24 April, he requested a further transfer to Buckley Hall. On 2 May, he was told about a possible transfer to HMP Stocken, and it was noted in his history sheets that he was receptive. He transferred to Stocken on 22 May. Although his ACCT document had only recently been closed, he told staff before the transfer that he

did not feel vulnerable or at risk of harming himself.

30. The man settled quickly at Stocken. Staff regularly noted in his prison record that he raised no problems or concerns and appeared in good spirits. However, on 14 July, he told staff that he wanted a further transfer. He was told that was not an option as he had moved three times already during the period of his current parole application. He was advised to settle down, improve his behaviour and gain employment, in order to assist his application for parole. However, staff noted that he was not happy with this advice.

31. On 17 July, the man barricaded his cell and was removed, under restraint, to the prison's segregation unit. He told staff that his actions were a consequence of his frustrations and wanting a transfer to HMP Erlestoke. He was told that his security category was to be upgraded from a category C to a category B prisoner, a retrograde move. He admitted to staff that he had a number of "issues" which needed to be addressed and that he had "… not been in the right place" for sometime. (Category B prisoners are those for whom the highest security conditions are not necessary, but for whom escape must be made very difficult. Category C prisoners are those who cannot be trusted in open conditions but who would not have the ability or resource to make a determined escape.)

32. As a result of his re categorisation the man was transferred to Rye Hill on 5 August, where he settled quickly. He got a job, and said that he was happy that he had something constructive to do. He complied with the prison's rules and regimes, was polite to staff and associated well with other prisoners.

33. In early November, he alleged that he had been bullied by another prisoner. He told staff that he did not want the perpetrator to be spoken to in case it made things worse for him, or for the anti bullying strategy to be put in place as prisoners were already calling him a "grass". However, he declined to be moved to another wing and agreed to tell staff about any further incidents. He made no further complaints about bullying during the remainder of his time at Rye Hill.

34. On 20 November, the man asked for his third parole hearing to be deferred for six months. He said that this was due to obtaining new solicitor who was unfamiliar with his case and proceeding would be a waste of time. However, due to submitting his deferral papers late, the Parole Board hearing went ahead as scheduled on 15 December. As a consequence of having no legal representation, he represented himself.

35. On 29 December, the Parole Board reported on its consideration of the man's release and transfer to open conditions. The Board reported that he had incurred 11 adjudications since his imprisonment, four in the previous year and that he had been re-categorised from category C to category B following the barricading of his cell. The Board also noted that he had failed to put into practice work undertaken in a number of programmes to address his offending behaviour. Also he had been transferred to a number of prisons but had not settled. The forensic psychologist, with whom he terminated interviews and refused to meet on numerous occasions, concluded that he should remain in

closed conditions in order to undertake work to address his risk of violence against his partner. The Board reported that his tendency to impulsive and aggressive behaviour and difficulty deploying coping strategies, added to his risk. A period of stability in one establishment would be required to build up his coping skills and confidence. The Parole Board concluded that he should stay in a closed prison and continue to work towards reducing his risk of re-offending.

36. During the remainder of the man's time at Rye Hill, staff frequently described him as polite, respectful and complying with all the rules and regimes. He was seen as making excellent progress. In late January 2009, he made an application for transfer to Grendon, saying to staff that he felt he would benefit enormously from its therapeutic regime.

37. The man wrote to the Population Management Coordinator at Grendon on 25 May to ask how his application for transfer was progressing. He wrote that he was six years post tariff and that Grendon was his only hope of a successful parole hearing. She replied that, pending a screening process and review of security issues, he would be told whether or not he was suitable for transfer.

38. On 20 July, the man was accepted as suitable for further assessment at Grendon. He was told that, if accepted for therapy on completion of the induction and assessment process, a commitment of two years and a willingness to abide by the expectations of the community would be required. He was also informed that, should he be accepted, he would have to forego any application for parole for at least 12 months. This was because the therapy required a commitment of at least 18 months. On 18 September, he signed a deferral form confirming his wish to defer his Parole Board hearing for 18 months. On 28 July, he transferred to Grendon and was allocated to live on the prison's Assessment and Induction Unit.

At HMP Grendon

39. On arrival at Grendon, the man was interviewed by an unidentified member of staff who completed an initial assessment and induction form. He provided a full history relating to his family and offence. He also provided details of self harm attempts and previous therapy. He told staff that he had tried to commit suicide previously by cutting his wrists. He said that he had done this because he felt sorry for himself, seeing other prisoners being released before him and believed that he would never be released. He said that he had gone on a ten day hunger strike two years previously as a protest at being so many years over his tariff. The rules and regimes were explained to him and he signed a number of compacts acknowledging his understanding of them.

40. The man's first community group session took place on 29 July, his first full day at Grendon. He talked about his problems with alcohol, but denied being an alcoholic.

41. On 30 July, the man made a telephone call to a friend. He explained how he was settling in at Grendon and predicted that therapy over the next two years would be demanding for him. He talked about sending out visiting orders to his

friend and said that, compared with eight years ago when he was last at Grendon, there was less freedom but the food was good. My investigator thought that throughout the conversation with his friend the man sounded relaxed and calm.

42. During his second community group session on 5 August, the man said little. Towards the end of the session he wanted to pursue an issue but was unable to do so as the meeting was ending.

43. A Registered General Nurse (RGN) completed a healthcare admission questionnaire on 6 August. The man told the nurse that he had an elbow pin and suffered from a back injury. The nurse documented that he had a previous history of depression, harming himself and had attempted suicide. However, the nurse noted that he was not receiving any treatment at the time of his transfer to Grendon.

44. The man was visited on the induction wing on 7 August by a mental health nurse, a Registered Mental Nurse (RMN). He recorded that the man expressed no immediate health concerns and denied any suicidal thought at that point.

45. Shortly after lunch on 8 August, the man telephoned his friend again and said that things were going as well as they could. They talked about contacting his new barrister and his friend reassured him that everything would be okay. He suggested that the man write to bring his barrister up to date. He told his friend that people at the prison did not understand and talked of the prison's inefficiencies. He said he was not fortunate enough to have a good solicitor to represent him. Later that afternoon he called his friend again, advising him that he had arranged for visiting orders to be sent out. He talked of other prisoners, who had received higher tariffs than himself, but had already been released from prison.

46. On 10 August, the man spoke with his friend once again, seeking additional information in order to complete the visiting order. In a telephone call two days later, he again spoke about arranging a visit to the prison.

47. A prisoner, who was a member of the man's community on the induction unit, told my investigator that they often spoke together. The man had told him on one occasion that he was unhappy with his legal representation. The prisoner provided him with the contact details of his own solicitor. He said that the man had learnt recently of the reasons for his parole refusal, believing that this had been a "turning point" for him.

48. Four days later, on 14 August, the man was assessed by one of the prison doctors. She told the investigator that he had made an appointment as he was suffering from lower back pain, which he told her he had experienced for the previous ten years. He said the pain had been affecting his sleep and he wanted to see a chiropractor. She referred him to the prison physiotherapist. She said that he expressed no other concerns during the consultation.

49. At the man's third community group session on 12 August, he discussed the death of his sister through drug abuse, challenging another prisoner about his own addiction. He also revealed to the other prisoners that he had issues relating to trust and struggled to disclose personal feelings.

50. On 19 August, after the man's fourth group meeting, staff noted that he found it difficult to open up, was defensive and did not believe he would be at Grendon for long.

51. An officer completed an Assessment Unit Progress Report on the man. It noted that the man was, "Being closed down to the community, keeping himself to himself and suspicious of others, point scoring. Struggling to build upon relationships." The officer noted that the man felt angry about a previous refusal for a transfer to an open prison and that he was five to six years over tariff. He was set a number of targets including becoming more trustful, engaging in community activities and avoiding feelings of injustice.

52. On 26 August, during the man's fifth group session, staff recorded that he said very little, challenging a prisoner who felt his sentence was harsh, but listened to others in the group.

53. An officer wrote in the man's wing history sheets on 27 August that he had spoken of his wish to return to Rye Hill because he did not need to engage in therapy. However, after further consideration, he decided that he would continue the assessment period at Grendon.

54. At the man's sixth and final group session on 2 September, staff noted that he did not speak until the end. When asked why, he said that he had issues with regard to trust and paranoia, expecting people in authority not to do the right thing.

55. On 4 September, the officer again recorded the man's wish to return to Rye Hill. The officer noted that he became annoyed with staff after they told him that an incorrectly addressed postal order would need to be returned to the sender.

    In response to the draft report the man's friend said that on 5 September 2009, he and a friend visited him in prison. He said that it was apparent that he was vulnerable and at risk. The man's friend says that a notice invited visitors to phone a named member of staff should they have any concerns. He said that he telephoned the number the following week and was told that as the staff member named on the notice had been transferred to other duties he should speak to staff on the man's wing. Having spoken to staff on the wing he said he was advised that he should write to the Governor. He did not write to the Governor believing that he would require the permission of the man to do so. He said that he did not speak with the man again.

    My investigator spoke to Grendon's Safer Custody Manager about the notices. She confirmed that notices were displayed inviting friends and family to contact the prison should they be worried about someone in prison. She confirmed that the posters were in place when the man was at Grendon.

The posters invite staff to contact the Safer Custody Manager, Duty Manager or Duty Governor before leaving the prison, or to phone the prisons general number asking to speak to the same. The poster also provides contact details for the Prisoners' Families Helpline and Samaritans, who would forward information to the prison, if no member of prison staff was available.

56. Just over a week later, on 12 September, an officer recorded that the man, whilst cleaning the staff office that morning, became negative about his job when he was asked to place a 'wet floor' marker down. He told the officer that he did not like the job anymore and walked out, returning to his cell. He explained his actions to the officer the following day. He told the officer that he struggled to trust staff due to previous experiences that had a negative impact on him. They discussed the need for him to make his mind up whether to commit to Grendon or return to Rye Hill. The officer went on to report that the man subsequently arrived for work on time, carried out his duties to the required standard and with an appropriate attitude.

57. However, on 14 September, another officer reported that the man again refused to do his work and had now been sacked. The officer noted that the man had repeated that he wanted to leave Grendon. It was also recorded that he was no longer participating in therapy.

58. On 15 September and again on 23 September, the man failed to attend the weekly group session.

59. The man went to healthcare on 20 September where he was assessed by a RGN. She wrote in the medical record:

    "Attended at treatments stating was constipated, hadn't passed stool for eight days. Also states had given meals away for those eight days as couldn't eat due to constipation. Advised fluids, roughage and increased exercise which he states he can't as he has a bad back. Contacted wing to ask them to observe diet and if he is giving food away … "

    She prescribed two tablets of Sennakot (a laxative) and advised him to return should he need more. Given his presentation, she told the investigator that she believed he must have been eating some food.

60. On 23 September, the man received physiotherapy for his back pain from the prison's physiotherapist. She wrote in his medical record that he was agitated during the session and told her that he did not want to stay at Grendon.

61. An officer wrote in the unit's observation book that an officer had spoken with the man to advise him that he would be returning to Rye Hill. He noted that this was requested by the man as he was withdrawing from therapy. The prisoner and community member told my investigators that the man was very frustrated after the meeting with the officer, saying that he did not want to return to Rye Hill. The prisoner said the man seemed ambivalent about returning to Rye Hill, although he wanted to leave Grendon. Nevertheless the prisoner felt that he did

not want to return. He said that the man told him that he was bullied by a Rye Hill officer and something seemed to concern him about his imminent return.

62. At 3.35pm the following day, 24 September, a student nurse, having been alerted by wing staff, spoke to the man, about why he had been collecting his meals and throwing them away. He said he was depressed and frustrated due to his lack of independence and was fed up with life, wanting to see his family in the 'after life'. The student nurse wrote that he was not eating but was drinking four cups of tea a day. He said that he had not eaten for 13 days. He agreed to be referred to a community psychiatric nurse.

63. Following the student nurse's meeting, a RMN talked to the man at 4.00pm. She recorded in his medical record that he was very eloquent in his desire to continue with his food refusal as a means of suicide. He told her that he had felt unsafe in previous prisons. He talked about staff corruption, bullying and that his life had been threatened by other prisoners. He believed he had family waiting for him in an "after life" and expressed strong religious convictions. He told the nurse how he saw no future and that the final outcome for everyone was death. However, he expressed no suicidal ideas saying that he felt safe on the induction wing. She explained that the prison had a duty to provide him with a mental health assessment and that, due to his food refusal, checks on his physical health would be taken. She also referred him to be assessed by a member of the MHIRT the following morning.

64. At 4.45pm, an officer spoke with the man, following his appointment with healthcare staff. He told the officer that he had not eaten since 12 September and that it was his intent to starve himself to death, believing in an "after life" and "as a way to end it all". The man added that he would not harm himself in any other way. At 4.55pm, shortly before being locked back up in his cell, the officer spoke with him again. He told the officer he was adamant that he would not eat again and had told healthcare about this. When advised of the various support plans, he said he did not want "all this attention" and did not want to be put on an ACCT.

65. The officer opened ACCT procedures at 5.15pm. As part of the ACCT process, staff agreed an immediate action plan. This included the man remaining in his current cell where he felt safe, and being offered the support of other members of the community and staff. The required frequency of observations and conversation were set as once in the morning, afternoon, evening and during routine patrols at night.

66. A food refusal form was started. (The form is used by the Prison Service to monitor whether the meals provided to a prisoner are eaten.) It was recorded on the form that the man had been offered his evening meal but declined to take it. He remained in his cell during the evening watching television, and caused no concern to staff. He was checked another four times during the night and was each time asleep. Another officer wrote in the unit observation book advising staff that the man was to collect his food from the wing office and it was to be recorded in the food refusal log. The officer also wrote that, if he refused food for 72 hours, healthcare staff would take over his care and he would be subject

to daily urine tests to confirm whether or not he had eaten.

67. At 6.30am on the morning of 25 September, the man signalled, when checked by an Operational Support Grade (OSG) that he was okay. At 8.15am an officer spoke with him and they discussed the television programmes that he had watched the previous evening.

68. The man went to healthcare to provide a urine sample at 8.45am. A RGN noted that the sample showed significant abnormalities. The nurse noted a high level of ketones, suggesting that he had not been eating properly recently. (Ketones are produced normally by the liver as part of fatty acid metabolism. In normal states ketones will be completely metabolised so that very little, if any, appear in the urine. If someone does not eat for more than a few hours then the body will run out of glucose [sugar] stores and will switch to breaking down fats and produce ketones.) At 10.00am the man told an officer that he was happy with the support he was receiving from staff on the unit.

69. The man was interviewed by a nurse and manager of the MHIRT, at 10.30am. He told the nurse that he had been on hunger strike for two weeks and had "had enough", citing his harsh treatment and the unfairness of prison as triggers to his decision to refuse food. He said he had no other plan to end his life and was scared of deliberately harming himself. The nurse noted that he was relaxed and pleasant during the assessment, maintained good eye contact, coherent speech and concentration. The nurse encouraged him to attend his ACCT reviews and offered weekly one to one sessions for support and to discuss coping strategies. He told my investigator that he did not believe the man was suffering from any severe or enduring mental illness, but from depression. He said that the man had asked to be sent back to Rye Hill as he no longer wanted to stay at Grendon. The nurse said that he appeared keen to go back.

70. An officer completed an ACCT assessment interview with the man at 11.30am. The man said that he had had no contact with his family and only little contact with two religious friends. The officer wrote in the review that the man "… has the feeling that death and his belief in the after life is an escape from prison as he has no chance of release from prison in the future." The officer noted that he had no trust in the prison system saying that he was victimised and staff were corrupt. The man told the officer that he was anxious about his imminent return to Rye Hill, adding that he only felt safe and trusted the staff at Buckley Hall.

71. At 11.55am a second officer provided the man with his packed lunch shortly before being locked in his cell. The officer told my investigator that she was surprised when she learnt that he had been refusing food since 12 September, as his appearance did not indicate this. At 1.20pm a third officer asked him if he had managed to eat any of his lunch and he replied that he had not as he was not yet ready to do so.

72. An assessor chaired the man's first ACCT case review at 1.37pm following his earlier assessment interview. The second and third officers also attended. At the meeting the man talked of his feelings of anger, helplessness and bitterness. He said he felt he would never be released and saw no way forward, raising

issues regarding his perceived injustice. He told the officers that he was misunderstood and, although staff were supportive, he felt isolated and exhausted. The care plan was updated and the next ACCT review was scheduled to take place on 28 September.

73. In interview the second officer told my investigator that she believed the man was unhappy at Grendon, wanting to go to Rye Hill. However, she said that when he was told he would be returning, he changed his mind claiming that he did not want to be sent back. She said she did not believe he really wanted to be at Grendon in the first place and may only have come to the prison in order to satisfy the Parole Board.

    In response to the draft report the man's friend says that having been involved in the man's request to transfer to Grendon and having made telephone calls on his behalf he is of the view that the second officer misread the man's motivation and purpose.

74. At 4.15 pm the third officer noted in the ACCT on-going record, wing observation book and food refusal log that the man had collected a full plate of food from the servery and was eating it. He also noted that he had taken a quantity of biscuits back to his cell.

75. A fourth officer checked the man at 8.30pm. He recorded that he was sitting in his cell in the dark watching television and gave no response when asked if he was okay. The officer said his behaviour did not unduly concern him, adding that prisoners frequently ignored staff when they were checked at night. However, the officer explained that if he had had any concerns he would have raised them with the duty manager immediately. He told my investigator that the man appeared to be very suspicious and hostile towards uniformed staff, kept himself to himself and did not particularly mix with other prisoners. At 8.55pm the OSG similarly noted that he was in bed under his blanket, in the dark. He said that his television was on, but he said nothing to him.

76. In the early hours of 26 September, the OSG began his routine checking of the unit which included checking the man. At 12.00am the OSG once again noted that he was in bed, under his blanket and the television was on. The OSG said that, although he did not speak with him, he saw that he was breathing.

77. The OSG checked on the man again at 1.40am. On opening the cell's observation flap, he saw him sitting on the floor with his legs out in front of him. He told my investigator that:

    > "… a sheet was round his neck and his head was tilted to the right and obviously the sheet had been attached to the window, and the chair and the tables and everything, obviously had been moved around. I banged on the window a couple of times and I turned the light switch on a couple of times, but I knew he was dead then because obviously there was no movement at all, so straightaway I got on to my radio, I got in touch with control and I said to them this is Bravo five urgent message, I said could you get all the staff to come down to the wing immediately …"

The OSG returned to the area in front of the unit office to await the arrival of assistance.

78. A Senior Officer (SO), Oscar 1, was in the staff mess when he heard the OSG's request for him to attend G wing. (During night shifts in prisons, the most senior officer, commonly known as Oscar 1, is responsible for the running of the prison.) Whilst making his way to the wing he met a fifth officer, who was also responding to the call for assistance.

79. Arriving on the wing at 1.42am, the officers were met by the OSG who told them a prisoner in cell 4-07 was having problems. The SO enquired as to the problem and was told by the OSG that he thought the man was dead. The three officers made their way to the landing gate, beyond which the man's and other cells were located. The SO asked the OSG to open the landing gate. (Because cells at Grendon do not have in cell sanitation, each landing has an additional locked gate. This allows prisoners to be let out of their cells to access the toilets during the night, but not to have access to the main wing. If a prisoner has been let out of his cell to go to the toilet, officers are unable to access this landing.)

80. The SO said that he arrived at the man's cell within approximately 30 seconds of arriving on the wing. On looking through the observation flap, he saw that he was slumped, sitting at the back of the cell with a green bed sheet tied around his neck. The SO told my investigator that, by the way he looked and based on his own previous experiences, he believed he had already died. The SO immediately asked a sixth officer, the control room operator, to electronically unlock the cell door.

81. At approximately 1.43am the SO and the fifth officer went into the cell. The officer attempted to lift the man from the floor, to assist the SO in cutting the ligature free. Unable to take his weight, she was assisted seconds later by a seventh officer who had also responded to the call for assistance. Having cut the ligature free, the officers laid the man on the cell floor. Despite his own belief that he was dead, the SO asked the seventh officer to check for vital life signs and to start cardio pulmonary resuscitation (CPR) while he left the cell with the fifth officer to call an ambulance.

82. On his arrival on the wing an eighth officer assisted the seventh officer. The officers established that the man showed no signs of life, had no pulse, was very cold and both his eyes and mouth were fixed. The officers told my investigator that there were clear signs of rigor mortis which made CPR impossible. The officers placed a blanket over him and left the cell, returning to the wing office to await the arrival of the paramedics. The OSG confirmed that after the arrival of the officers he did not enter the cell or assist with CPR, but returned to the wing office as instructed by the SO.

83. The control room incident log records that an ambulance was called at 1.43am. It arrived at 2.00am and the paramedics were escorted to the wing on foot, arriving at around 2.06am. The man was pronounced dead by the paramedics

at 2.10am.

84. A hot debrief was held later that day and was attended by staff who had been involved in the discovery of the man. I also understand that the staff care and welfare team approached those members of staff which was very much appreciated by all of the staff with whom my investigator spoke. A review of all prisoners on open ACCTs was also completed by members of the safer custody team.

85. The man's next of kin, a friend, was told of his death that afternoon by the prison's family liaison officer and duty governor who travelled to London to break the news. Grendon offered funeral expenses and a memorial service was held at the prison at which community members attended and took part in. The man's body was returned to London where he was subsequently buried.

ISSUES

Clinical care

86. In his clinical review, the clinical reviewer reports that the man presented with chronic back pain for much of his time in prison and received appropriate treatment, through physiotherapy, for the condition. He says that during the ten years he spent in prison, the man received appropriate responses from primary and secondary level healthcare services.

87. Suffering significant harm during the man's early childhood due to the neglect and abuse by his parents, the clinical reviewer says that this led to a complex personality disorder in adulthood. He writes that, although he presented as depressed at times during his sentence, the man did not appear to have a clinical depressive illness. He reports that the man had a history of harming himself and, during his time in custody, made numerous threats and gestures to taking his own life. Although he had said he was too much of a coward to take his own life, he often spoke of his wish to die. The clinical reviewer notes that, although assessed as clinically depressed, the man was able to mask his true feelings from staff.

88. The clinical reviewer reports that antidepressants prescribed to the man were inconsistently collected, or that he would simply stop taking them. Finding that they made little difference, he preferred to cope on his own. He says that despondency and bitterness at his predicament led him to refuse food for periods with the express wish that his life should end. This became more frequent through 2008-2009.

89. In his clinical review the clinical reviewer says that no assessment of suitability for psychotherapy in a therapeutic community, such as Grendon, was prepared before his arrival at the prison. He reports that there was just one care plan, on 19 August, aimed to help the man engage in the therapeutic community whilst he was there. This was in order to build trust and avoid feelings of injustice.

90. The clinical reviewer reports that the man was clearly unhappy at Grendon and wanted to leave, possibly because he was more exposed to challenge from his peers than he would have been in an ordinary prison. He says that, isolated from his peers, he began to withdraw from the community, resulting in his non attendance at community meetings in the weeks before his death. During this time he became defiantly agitated about going back to Rye Hill, hoping for another placement at a different prison. However, the clinical reviewer says that there was no evidence of any work done with him around this area of disappointment and future options, other than acknowledgment of his agitation at his poor prospects. The clinical reviewer says no specific support was identified to assist the man with this or with the decision to return to Rye Hill. He was therefore left with this distress over his last weekend. However, the clinical reviewer says that it was probably unlikely that a team meeting, planned for the following Monday, but did not take place because of the intervention of his death, would have affected a satisfactory alternative.

91. The clinical reviewer reports that some of the medical documentation was confusing. In particular he says that the entry by the nurse, which was undated but completed in the induction unit after the man's arrival, was below standard. He says that there was sufficient information,

    "… known about the man on first assessment at Grendon to have alerted staff to the high risk with his mental health and for them to make referral to the psychiatrist for urgent review."

    He notes that the man was not seen for a general health screening until 6 August and that when assessed on the wing by the nurse, one of the mental health nurses on 7 August, he was regarded as low risk for self-harm despite his long previous history of significant mental health disorder. He concludes that given the entry in the medical record it can only be assumed that the consultation was brief.

92. The clinical reviewer says that the man had a history of refusing food as a protest against the injustice that he felt and as a way to end his life, feeling too cowardly to commit suicide. He said that the man's previous recoveries and ability to resume everyday life may have misled staff into thinking his actions were manipulative. He said there was a suggestion of this in the uncertainty that he was really discarding all food and in the evidence that he was not dehydrated and appeared fine to staff. However, he notes that a regular check of his weight loss would have confirmed his food refusal, as did the heavy presence of ketones in the days leading to his death. The man lost almost ten kilograms in weight in six weeks at Grendon, but notes that there were only two separate measurement points recorded in his medical record. (My investigator could not find reference to weight loss in the medical records). He says that it does not appear that the man was monitored daily for food and fluid intake and output. Blood pressure, pulse, weight and regular urinalysis were not taken as they should have been, as should referral to the prison GP.

    In his clinical review the clinical reviewer makes a number of recommendations. I urge the Governor and Head of Healthcare to consider the relevant findings carefully.

Assessment, Care in Custody and Teamwork training

93. During the investigation my investigator established that the second and third officers, who took part in the man's first case review, had not been trained in the ACCT process, but nonetheless had taken part, by attending ACCT reviews and writing directly in the on-going record.

94. PSO 2700, Suicide Prevention and Self-Harm Management, section 1.2.1 states that,

    "All staff in contact with prisoners must be trained to at least ACCT Foundation level … be aware of the signs of risk … and when caring for at-risk prisoners follow the ACCT procedures set out …"

95. I make no criticism of the officers. Who demonstrated a good understanding of the ACCT process to my investigator. However, I am disappointed to learn that they have not been provided with formal training.

The Governor of Grendon must ensure that all staff have received the minimum of foundation level training in ACCT.

Emergency response

96. As I have already reported, the man's death was the first apparently self inflicted death to have occurred at Grendon for many years. As a consequence it is fair to say that staff at the prison are not as well versed at dealing with such an emergency situation as their colleagues in some other prisons. Although it would appear to be clear that he had been dead for some time and it is apparent that no intervention or indeed quicker response would have altered that outcome, there are a number of lessons to be learnt in order to improve emergency response systems for the future. I set these out as follows.

Delay in entering the cell

97. When he found the man hanging, the OSG raised the alarm but did not immediately go into the cell. He returned to the main corridor to await the assistance of responding staff. My investigator asked the OSG if there was any reason why he had not entered the cell immediately he discovered the man. The OSG said that he would never do anything like that, because he would always make sure he had an officer with him. When asked whether he had been told that another officer must be present before opening a cell, the OSG said:

> "Yes, any incident you have got to make sure you have got an officer with you. You never do anything on your own, you always make sure you have got someone with you and I never entered the cell as soon as I saw him. Like I say I went straight on to the radio and that was it and then I let all the officers deal with it …"

98. My investigator reviewed Grendon's local night instruction for dealing with a suspected death in custody. The local instruction 2.87, June 2007, Nights – Death in Custody/Suspected Death in Custody provides guidance on what action staff should take. It states that on raising the alarm, the night patrol, having contacted the control room, informing them of the cell location, "… must gain access to the cell, if this is assessed as safe to do so" Having removed the ligature from around the neck, they should give appropriate first aid. Similarly the prison's local policy for a Death in Custody states that on discovering a prisoner who may have died, staff should immediately summon assistance and, "Enter the cell / area (in these circumstances you may do so alone)."

99. The OSG said that he could see that the man had hanged himself. He confirmed to the investigator that he was aware of the night procedures, but did not immediately enter the cell to assist as stipulated in the procedures. It was apparent to my investigator that the OSG was not fully aware as to the circumstances of when he could enter a cell at night, and did not know the

actions to take following an apparent death in custody.

100. However, given the evidence of the other officers, it is clear that the man had been dead for some time. Even if the OSG had entered the cell immediately his assistance would not have altered the outcome. Nevertheless a prompt response is essential, and in a similar situation, could save a prisoners life.

The Governor should remind all staff of the procedures and actions to be taken at night upon discovering a death or suspected death in custody.

Emergency response codes

101. The SO was in the staff mess when he heard the OSG's request on the radio for him to attend G wing immediately. The SO said he was not aware of the nature of the emergency to which he and the fifth officer were responding. He said he walked to the incident, albeit quickly, but would have run had he known that the man was found hanging.

102. My investigators discovered that there appeared to be a lack of awareness amongst staff as to the emergency call signs. The OSG did not use a code when requesting assistance. I understand that Grendon uses a level one, two and three emergency code system. The SO said that level one was used to alert staff of a hanging, level two, blood loss and level three is used for other non life threatening situations. However, he told my investigator that he believed the codes were not widely known by staff because they were seldom used. The seventh officer's understanding was that codes were used during the day when healthcare staff were on duty and that at night there was no formalised code system. Adding that if someone says "Oscar to G wing" everyone knows there is an emergency and should attend immediately. The sixth officer, who was working in the control room that evening, said that she was not aware of any codes to be called in an emergency.

The Governor should remind all staff of the emergency calls to be used when summoning assistance, throughout both the day and night.

103. Although I appreciate that there are no mandatory requirements for prisons to use any specific emergency code system, many prisons use a call system such as code red (for blood loss), code blue (for breathing difficulties) and code yellow (for non life threatening). These codes inform staff of the nature of an emergency in language that is easily understood. Although I make no formal recommendation, I invite the Governor to consider whether or not the introduction of such a system would assist staff when they are responding to an incident.

Access to landing

104. The SO told my investigator that when he arrived on G Wing the landing gate leading to the man's cell was locked and he had to ask the OSG to open it. The SO was surprised that the landing gate had not been left open in view of the fact that a prisoner on the landing was having problems. He agreed with my

investigator that had another prisoner been let out of his cell to use the toilet, during the time that the landing gate had been closed, immediate access to the wing would have been compromised. Although the slight delay in accessing the man's cell would have not altered the eventual outcome, I make the following recommendation.

The Governor should remind all night staff that upon discovering an incident in a cell the landing door should remain unlocked in order to allow immediate access.

Calling of an ambulance

105. The man was discovered by the OSG at 1.40am but it was only on the arrival of the SO, three minutes later that an ambulance was called. It is essential that ambulances are called immediately to life threatening situations. Any delay can have a significant impact on a person's chances of survival and the first on scene should, having made an immediate assessment of the situation request one should they believe it to be necessary. If not required the ambulance can always be cancelled at a later time.

106. A Letter to Governors from the Director of Prison health in March 2004 advises that:

> "It is also essential that internal procedures should not waste undue time in summoning emergency assistance. It should not for example, be a requirement in every case for a member of the Health Care Team to attend the scene before Emergency Services are called. However, a subsequent 999 call to the Ambulance Service should be made to cancel the response if, after the original 999 call has been made, a member of the Health Care Team arrives with the patient and deems that an emergency ambulance response in not required."

The Governor of Grendon should remind all staff of the importance of calling an ambulance promptly.

107. This would be another benefit of using a coding system for emergencies as highlighted earlier in my report. Some other prisons operate a system whereby if the highest severity call is made an ambulance is automatically called immediately by the communications room staff, leaving officers on the scene free to assist.

First aid and defibrillator training

108. It became apparent during the investigation that, although a number of the night officers had received previous first aid training, not all of that training, including their CPR training was up to date. Although staff did not attempt to resuscitate the man, speedy intervention by properly trained and qualified staff can often make the difference between life and death. Had he needed resuscitation I am confident that the officers present would have delivered it to the best of their knowledge, based on their previous training. However, I think it essential that

discipline staff, in particular where there is no support from a night nurse, should have the confidence and up to date knowledge to carry out first aid and CPR effectively.

The Governor should provide training in first aid and cardio pulmonary resuscitation for all staff who work permanent nights.

109. Several officers told my investigators that they did not know where the defibrillator was kept in the prison. Access to any life saving equipment is critical during an emergency and easy location, speedy recovery and prompt use is essential. Given the evidence of staff who found the man, I do not believe that using the defibrillator would have helped to save him. However, on another occasion it might be critical.

The Governor and Head of Healthcare should review the location and availability of defibrillator equipment at Grendon, ensuring that all staff are aware of its location.

CONCLUSION

110. During his ten years in custody the man made many attempts to harm himself, including refusing food to protest against the injustice he felt at not having been granted parole seven years after his tariff had expired. In the latter years of his sentence, this refusal of parole appears to have had a significant impact upon his actions. His behaviour would on occasions deteriorate significantly and it is apparent that he became difficult for staff to manage. The clinical reviewer concluded that this behaviour, which was followed by recovery and to resuming everyday life, may well have led staff to believe that the man's actions were manipulative. Although he was a demanding and sometimes difficult prisoner, there is no evidence to suggest that this was the case.

111. In the weeks leading to his death the man, despite support from the community at Grendon, appears to have withdrawn from active participation. His apparent refusal to eat, which was only brought to the attention of staff in the days leading to his death, appears to have been a mechanism, used on previous occasions, to draw attention to his plight and inner feelings of uncertainty and insecurity. Although staff opened the ACCT procedures, food refusal form and care plans, and took time out to discuss with him his predicament, he appears to have hidden his true feelings and intent to end his life from staff.

112. Both healthcare and discipline staff at the prison fully engaged with the man in the days leading to his death. However, I do not believe that they could have understood the impact on his failure to succeed at Grendon, and thus obtain parole. Neither could the staff have understood how the knowledge that he would return to Rye Hill had upon his thinking. It is perhaps only with the benefit of hindsight that consideration can be made as to whether this disappointment could have been better managed. I concur with the clinical reviewer when he says that the man's

> "… death by suicide seems to have been an inevitable outcome for him as he had indicated at times over the last three years within his predicament. The prison system, he felt, had given him no support or hope for an alternative life."

113. I make seven recommendations, predominantly relating to the emergency response. I also urge the Governor and Head of Healthcare to give further consideration to the findings of the clinical reviewer in his clinical review.

RECOMMENDATIONS

1. The Governor of Grendon must ensure that all staff have received the minimum of foundation level training in ACCT.

   Accepted - *The establishment has in place a programme to ensure the delivery of ACCT Foundation training to staff in accordance with PSO 2700, Prison Service Standard 60 and the local Suicide Prevention & Self Harm Policy. The implementation of the programme will be monitored by the Safer Custody Lead and will be further supported by the training of extra staff to deliver the foundation module. Once staff have received their initial training, they will be required to attend a refresher within 3 years.*

2. The Governor should remind all staff of the procedures and actions to be taken at night upon discovering a death or suspected death in custody.

   Accepted - *The Governor will ensure the local procedures for the 'Night State' are subject to a full and comprehensive review, once completed the revised instructions will be implemented and all staff, especially those at night will be made aware of their responsibilities and actions expected of them in the event of any emergency or incident*.

3. The Governor should remind all staff of the emergency calls to be used when summoning assistance, throughout both the day and night.

   Accepted - *The Governor issued instructions for staff (09/2009) informing of the procedures to be followed in the event of an emergency. By following these instructions, they will assist staff in responding effectively and efficiently to any situation.*

4. The Governor should remind all night staff that upon discovering an incident in a cell the landing door should remain unlocked in order to allow immediate access.

   Accepted - *The Governor will ensure the local procedures for the 'Night State' are subject to a full and comprehensive review, once completed the revised instructions will be implemented and all staff, especially those at night will be made aware of their responsibilities and actions expected of them in the event of any emergency or incident.*

5. The Governor of Grendon should remind all staff of the importance of calling an ambulance promptly.

   Accepted - *The Governor will ensure the local procedures for the 'Night State' are subject to a full and comprehensive review, once completed the revised instructions will be implemented and all staff, especially those at night will be made aware of their responsibilities and actions expected of them in the event of any emergency or incident.*

6. The Governor should provide training in first aid and cardio pulmonary resuscitation for all staff who work permanent nights.

Accepted - *A review of the training needs of permanent night staff (officers & OSG's) identified areas where staff have become de skilled. Therefore, the detailing of permanent night staff will cease by October 2010. Staff will work rotational nights as part of a fixed shift pattern. The Staff Development Unit and Group Managers will ensure staff working rotational nights receive First Aid & Cardio Pulmonary Training*.

7. The Governor and Head of Healthcare should review the location and availability of defibrillator equipment at Grendon, ensuring that all staff are aware of its location.

   Accepted - *Governor's order 09/2009 was issued to inform staff of the current location of the defibrillator equipment. Its location is subject to continued review until a sufficient amount of staff are trained in its use.*

8. I urge the Governor and Head of Healthcare to give further consideration to the findings of the clinical reviewer in his clinical review.

   Accepted - *Director Of Therapeutic Communities will ensure the PCT are made aware of the content of the report and that appropriate action(s) will be taken where identified.*