The Death of a man at HMP Wymott on 14 September 2005

Report by the
Prisons and Probation Ombudsman for England and Wales

July 2006

This report of an investigation into the death of a man at HMP Wymott on 14 September 2005 is one of the saddest reports I have ever issued as Ombudsman. The man was found hanging in his cell on B3 landing, part of the vulnerable prisoner accommodation at Wymott. He had been held at Wymott since January 2004 and was just 22 years old at the time of his death.

I offer my profound condolences on their loss to the man's mother, grandmother and other family members and friends.

The purpose of my investigation was to establish the circumstances and events surrounding the man's death, including the quality of care provided by the Prison Service. One of my Family Liaison Officers, made contact with the man's grandmother to explain how my investigation would proceed. The investigation was conducted by two investigators from my office. I also commissioned a Clinical Review from Chorley and South Ribble Primary Care Trust (PCT) and I am most grateful to the Head of Service Development at the PCT for undertaking that review. I must also thank the Governor of Wymott and her staff for the cooperation my investigators have received. I owe a special word of thanks to the Principal Officer who was appointed to liaise with my investigation team. The Principal Officer has acted professionally and effectively throughout the investigation.

Notwithstanding the seriousness of the offences that the man had committed, I must emphasise his own vulnerability and the learning and developmental difficulties with which he had to cope. At Wymott, he seemed to many staff and prisoners to be a boy in a man's world. He was not criminally sophisticated and had not been in prison before his current sentence. He was accustomed to receiving significant support whilst living in the community, and did not possess the life and social skills that would have enabled him to cope easily with imprisonment. The level of individual care and support he received during his months at Lancaster Farms YOI was extremely impressive. At Wymott, as an adult prisoner, he was expected to fend much more for himself. The man received notable support from some of the prisoners on his landing, but prison staff were unable to give equivalent support because they were unaware of his basic human needs and, in particular, of his bowel problem.

The circumstances of this young man's death are deeply saddening. Two haunting images remain in the mind. The first is the list, scrawled in his childlike hand, of the gambling debt of 27 Mars Bars that he owed to five separate prisoners. The second image is the pile

of soiled clothing that he tried to hide in his cell or in the wing laundry because he could not bring himself to tell staff about his bowel problem and they did not seem to know. By a tragic irony, a good-hearted officer discovered this problem on the last afternoon of the man's life, but he was found hanging before the officer could return to tell him of the help he had already arranged.

I have made a number of recommendations with particular reference to the Adapted Sex Offender Treatment Programme (ASOTP) which had reached an especially stressful stage on the day of the man's death.

Stephen Shaw CBE
Prisons and Probation Ombudsman
July 2006

CONTENTS

SUMMARY

1. The man was born in November 1982. He was found hanging in his cell at HMP Wymott on 14 September 2005. At the time of his death, he was just 22 years old.

2. During her pregnancy, the man's mother was taking anticonvulsant medication. After the man's birth, his family noticed a number of problems associated with foetal anticonvulsant syndrome (FACS). These problems include developmental delay, difficulties interacting with peers, poor fine motor control (holding a pen or knife) and bowel problems such as constipation and soiling. In childhood, the man was also given a diagnosis of dyspraxia (an impairment or immaturity of the organisation of movement). Developmental milestones may be delayed and dyspraxic children have difficulty in planning and organising thoughts. The man received significant community support during his boyhood and teenage years which were spent in Salford.

3. On 12 September 2003, the man was sentenced at Manchester Crown Court to six years detention in a Young Offender Institution for committing a number of serious sexual offences. He had been held in custody from 26 March that year so that psychiatric reports could be prepared. He had never been in prison before.

4. After brief spells at Forest Bank and Altcourse, the man was transferred to HMYOI Lancaster Farms on 27 June 2003. He received impressively detailed personal care during his time at Lancaster Farms. The man was admitted as an inpatient to the Healthcare Centre at Lancaster Farms on 2 October, when his primary problems were described as his learning disabilities and personal hygiene problems. He remained continuously in the Healthcare Centre until he was transferred to HMP Wymott, an adult prison, on 7 January 2004.

5. On 15 October 2003, the man made a noose from a radio lead. An officer patrolling his wing at the time noticed that he had red marks on his neck. A Self-Harm at Risk Form (F2052SH) was opened so that he could be given as much help and observation as possible whilst he was thought to be at risk of further self-harm. The form was closed just five days later and no further F2052SH was opened before the man's death.

6. Throughout the man's time in custody, there are references to him being tormented, bullied, exploited and mocked by other prisoners. However, once he was allocated to work in the Weavers' Shop at Wymott, he received commendably pragmatic and flexible support and guidance from the instructor, over the next 18 months.

7. During the last months of his life, the man also received excellent practical support from an older prisoner whose cell was on the same landing (B3). Several of the wings at Wymott, including B wing, are occupied by vulnerable prisoners. The older prisoner provided informal counselling for the man after staff had gone off duty in the evening. He taught the young man, whom he described as being like a 13 year old, how to tie his shoe laces and he supplied the man with extra clothing as best he could when he had soiled himself. Prison staff on the man's landing were not aware of his bowel problems.

8. The man initially denied his offences but then agreed to attend the Adapted Sex Offender Treatment Programme (ASOTP). He first attended an Enhanced Thinking Skills (ETS) course which concluded in February 2005, but the tutors on that course only became aware of his learning and developmental difficulties after it had ended.

9. The man and seven other men began ASOTP in June 2005. Evidence from a number of sources indicates that the man found the course a difficult and challenging experience. On the morning of his death (14 September), he was in the 'hot seat' where he had to give an account of his offences. However, he did not appear to be unduly distressed at the end of the session and agreed to continue with his account at the beginning of the next day.

10. Also on the morning of 14 September, an Officer, (Officer B) a regular on B3 landing, received two significant pieces of information about the man. Some prisoners complained about the smell coming from his cell and Officer B received a phone call from the instructor in the Weavers' Shop. The instructor had been told by the older prisoner that the man owed nearly 30 Mars Bars to a number of prisoners as a result of bets he had made and lost. The instructor kept the man back from work that afternoon so that he could discuss these matters. The man told the officer about his bowel problem and Officer B energetically set about obtaining practical support for him. He rang the Healthcare Centre and arranged with the Clothing Store for extra clothing to be delivered immediately to the wing.

11. At about 4.10pm, another prisoner looked into the man's cell and saw him hanging from the window bars. Staff ran to the scene when the emergency bell was pressed and did their utmost to save the man, but to no avail. The first three Prison Officers who arrived in his cell struggled to loosen the ligature from around his neck as there was a double knot and they had no anti-ligature knives.

12. The man was socially isolated as his family lived far away and he received no visits. He had not made any phone calls home in the weeks leading up to his death, although he did write letters. News of his death was broken to the family by police in their home town.

13. The circumstances of the man's selection for and ongoing membership of, the ASOTP have been very closely scrutinised during

this investigation. I have made a number of recommendations about the man's involvement with the course which have both local and national application.

THE INVESTIGATION

14. Since 1 April 2004, I have had responsibility for investigating all deaths in prison custody in England and Wales. This investigation was undertaken by two investigators from my office. They issued notices to staff and prisoners, telling them of the investigation and its terms of reference, and offering them the opportunity to participate.

15. My investigators visited Wymott on a number of occasions and inspected the cell where the man was discovered hanging. They interviewed both staff and prisoners who had had significant contact with the man. They reviewed all relevant documentation and spoke with the detective leading the Lancashire Police investigation into the man's death. They also met with the Chairman of the Independent Monitoring Board at Wymott, who had arrived at the prison very shortly after the man's death.

16. One of my Family Liaison Officers spoke with the man's grandmother and his nominated next of kin. The man's grandmother declined the offer of a meeting with the Family Liaison Officer and an investigator, but had a lengthy telephone conversation at a later date with one of my investigators.

17. I commissioned a Clinical Review of the care the man received at Wymott from Chorley and South Ribble PCT. I am most grateful to Head of Service Development at the PCT for undertaking the review. The investigator had a lengthy discussion with the Healthcare Manager at Wymott, about the issues of confidentiality and appropriate screening of potential ASOTP candidates.

18. Seven other prisoners were undertaking the ASOTP at the same time as the man. My investigators visited the group and asked if any of the men wanted to talk about the circumstances of the man's death. Two of them volunteered to do so and were interviewed on tape.

19. One of the facilitators who was leading the ASOTP on the morning of the man's death could not be interviewed as she was on maternity leave. However, she kindly made contact with my investigators and discussed a number of matters during a telephone conversation.

20. My investigators made early contact with the National Head of the Sex Offender Treatment Programme. I am obliged to her for providing a detailed letter about the circumstances of the man's death. She has given valued assistance throughout this investigation and watched with one of my investigators the video tape of the session on the morning of 14 September at which the man gave a detailed account of his offences. My investigators have carefully scrutinised national documents about the delivery of ASOTP,

including the 2003 Treatment Manual and the Accredited Programmes Audit Document issued by the Offending Behaviour Programmes Unit (OBPU) at Prison Service Headquarters.

HMP WYMOTT

21. Wymott is a Category C training prison for adult male prisoners. Over half of the population are vulnerable prisoners, many of them sex offenders. The prison is located on the outskirts of Leyland in Lancashire. The maximum number of prisoners who can be held at Wymott is 1046.

22. Responsibility for healthcare at Wymott transferred to the local PCT in April 2005. The Healthcare Centre has a doctor available every weekday. Overnight and weekend cover is provided by local GPs who are on call. There is also a clinically qualified member of healthcare staff on duty at these times.

23. There have been a number of natural cause deaths at Wymott since I assumed responsibility for investigating prisoner deaths in 2004. In addition, a prisoner was found hanging in his cell in the Segregation Unit in February 2005, and another prisoner was found hanging in his cell on a vulnerable prisoner wing (A Wing) on 21 June 2005. Although this latter prisoner did not die, I understand that he sustained permanent injuries and that he remains in hospital at the time of writing this report. The Area Manager commissioned an investigation and report from an experienced governor in another prison.

24. The prison was last inspected by Her Majesty's Chief Inspector of Prisons in December 2003. Her report was published in March 2004. Her overall judgment was that Wymott was a good and well-managed prison which provided work for almost all its prisoners. However, she noted that staff in general needed to be encouraged to engage more positively with prisoners, two-thirds of whom said that staff rarely spoke to them when they were out of their cells. The Healthy Prison Summary at the beginning of the report stated that a new anti-bullying policy was being rolled out but was not yet effective. The programme was not supported by staff training and there were no interventions or programmes for either bullies or victims. Most prisoners who claimed they had been the victims of bullying stated that it had been largely in the form of verbal intimidation.

25. In relation to health services, the report noted particular problems with access to doctors and long waiting lists to see GPs. The Chief Inspector stated that communication between the Healthcare Centre and the rest of the prison was poor. At the time of her inspection, there was little mental health service input for prisoners although there were plans to improve this in 2004.

26. The Chief Inspector also reported that work in the area of offending behaviour programmes had improved considerably and the prison

was on target to meet its required level of completions. She identified a need to tackle robustly the high number of sex offenders who were in denial of their offences. She added that the staff culture, which did not prevent this level of denial, needed to be challenged.

27. In the current financial year (2005-2006), the Head of Psychology and Programmes is the manager charged with the responsibility of ensuring that at least 36 prisoners complete a SOTP.

The Man

28. A great deal of information about the man is contained in a number of reports written before he was sentenced at Manchester Crown Court in September 2003. The first of these is a Social Background Report prepared in May 2003 by a social worker on behalf of Highland Council Social Work Service. The report stated that the man was born in 26 November 1982, and that during her pregnancy the man's mother was taking anticonvulsant medication. After his birth, both his mother and grandmother observed symptoms that were similar to common problems associated with foetal anticonvulsant syndrome (FACS).

29. The report also lists a number of problems associated with FACS. These include developmental delay, problems interacting with peers, no sense of danger, poor fine motor control (holding a pen or knife) and bowel problems (constipation and soiling). When the man was 10 months old, he moved with his parents to Salford and the family remained there until after the death of the man's father in 1998.

30. In June 1992, a Statement of Special Educational Needs was drawn up for the man. The report refers to a Health Assessment drawn up in 1994 for problems associated with soiling and food intolerances.

31. The man was given a diagnosis of childhood dyspraxia (an impairment or immaturity of the organisation of movement). Developmental milestones may be delayed and dyspraxic children have difficulty in planning and organising thoughts.

32. In 1998 and 1999, the man received support from the Salford Families Project (SFP). He did well under the guidance of his key support worker. He learned how to use public transport and go to the cinema, as well as improving his independent living skills.

33. The man's father died in January 1998, and his paternal grandfather died in December of the same year. After the two deaths, the man and his mother moved to a small village in northern Scotland and then to a Scottish town in January 2001. His younger sister remained in England.

34. The man enrolled at a Local College and he also attended the local Day Resource Centre. Both the College and the Resource Centre offered courses and activities for adults with special needs.

35. In March/April 2002, Greater Manchester Police contacted the social work office in the man's home town to arrange for him to be interviewed by police officers at a later date. Some months later, the man was taken to Carlisle for questioning about a number of serious

sexual offences which he had allegedly committed. On 26 March 2003, the man was found guilty on a number of counts at Manchester Crown Court. He remained in custody until 12 September 2003 when he was sentenced to six years detention in a Young Offender Institution.

36. At the direction of the Trial Judge, a number of reports were written between the man's conviction and sentence. A Consultant Forensic Psychiatrist at a hospital in Glasgow wrote his report on 6 May 2003. The man told the psychiatrist that he could not read but was able to write. The psychiatrist reported that *"his handwriting was rather odd and was confined to the extreme margin of the page which I had given him".*

37. The psychiatrist's view was that the man's intellectual functioning was significantly below average and he was probably *"at least borderline learning disabled".* The psychiatrist added that, when he was in the community, the man *"needed a considerable level of support from Social Services and now that he has been convicted of serious sexual offences his needs in terms of care and supervision are inevitably more complex, both while he remains in secure custody and at whatever point in the future he may be considered for return to the community again".*

38. The psychiatrist considered that, by reason of the man's mental disorder, it might be appropriate to make a formal recommendation to the court for a disposal under the Mental Health Act. The man told the psychiatrist that, prior to being taken into prison, he had always been under the care of a social worker and a keyworker.

39. A further psychiatric report on the man was prepared at the request of Manchester Crown Court by a Consultant Forensic Psychiatrist at Prestwich Hospital in Manchester.

40. In her report, the psychiatrist explained that she had interviewed a man at HMP Altcourse on 13 June 2003. He told her that since being in prison he had had boiling water thrown over his shoulders and he had been punched in the arms and stomach. He showed the psychiatrist a bruise on the inner aspect of his upper arm. At the time, he was being detained on a special wing for vulnerable prisoners. The man told the psychiatrist about two voices that were always arguing in his head. One was a Scottish woman who told him to do good things, the other was an English man who told him to do bad things such as robbing Post Offices. The man said he had lost three stones in weight, reducing from 23 stones to 20 stones. He said he had the occasional suicidal thought, including hanging himself. The man said that his family and his mates on the outside kept him going, but if he received a ten year sentence he would kill himself.

41. The Opinion Section at the end of her report said:

"Objectively he was not clinically depressed or demonstrating any signs of a psychotic illness. However, I cannot exclude the possibility of a psychotic illness, which may be depressive in nature. He would benefit from further assessment by a psychiatrist and a mental health team to assist in reaching a conclusion about diagnosis."

42. In another paragraph, the psychiatrist explained that, had the man been living in England, she would have been minded to recommend a Section 38 Hospital Order so that he could be assessed in an inpatient setting. She added that funding for such an assessment would be very difficult to arrange and that, because of bed shortages, it would take some considerable time before a bed could be located in an appropriate hospital somewhere in the United Kingdom. For that reason, she decided not to recommend a further adjournment to the court.

43. In a significant paragraph the the psychiatrist wrote:

"The man presents as a young man with learning difficulties. He has a long history of contact with Social Services and presents as functioning within the learning disabled range in many spheres. In his current environment he is very vulnerable and has been subjected to a number of assaults. It is likely that he will continue to be vulnerable from assault and abuse whilst in the prison system. The risk of self-harm is also high. I think it is unlikely that he would be able to undertake any meaningful offence related work in prison as he would not be able to cope with regular Sex Offender Treatment Programme groups being run in prison.

I believe there is also a risk of further deterioration of his mental health whilst he is in prison. In the event that he is given a custodial sentence, his mental health will need to be closely monitored and it is possible that he would require transfer to hospital for assessment and treatment of his mental health needs."

44. A third psychiatric report on the man was prepared in August 2003 by a Specialist Registrar in Forensic Psychiatry at a hospital in Middlesbrough. This report was written at the request of the solicitors acting for the man. The man told the registrar that he had not been able to achieve total faecal continence and, later in his report, the registrar wrote that the man had a long history of faecal incontinence dating back to his childhood.

45. In the Discussion section of his report, the registrar noted that the man presented as a young man with learning difficulties: "*Prior to being arrested, the man received a comprehensive care package from a variety of agencies in his community. It is likely that the man functioned at a reasonable level given the extensive supervision and support. Furthermore, the man benefited from attending college courses, specially designed for people with special needs … The man did not cope well, both academically and socially, whilst attending*

mainstream schooling. His functioning notably improved following his transfer to special schools."

46. In the Opinion and Recommendations section of his report, the registrar expressed his opinion that the man did not suffer from a major mental illness. The registrar repeated that the man had previously depended (to a large extent) on extensive support and supervision for his social functioning. He thought it very likely that the man would find it difficult to cope in prison. He had been assaulted by other prisoners and continued to be vulnerable. It was likely that he would be bullied and abused by other prisoners. The registrar thought the stressors in prison could negatively impact on his emotional wellbeing. He recommended that measures should be taken to ensure the man's safety, especially should a custodial sentence be considered.

47. The registrar recommended that:

"In the event of a custodial sentence, a copy of my report be sent to the prison medical officer, so that he may be aware of the man's problems and address them as appropriate."

48. On the last page of his report, the registrar addressed the question of self-harm. The man informed the doctor that he had superficially cut his wrists on two occasions as a coping mechanism to deal with the voices in his head. The man did not perceive any benefit from doing so and informed the doctor that he had stopped attempting to self-harm.

49. The doctor suggested that the risk of self-harm could be increased by the man's perceived inability to deal with stresses such as being bullied or assaulted whilst in prison. The risk of self-harm would be reduced by strategies to deal with bullying and measures to ensure the man's safety.

50. The Trial Judge, made lengthy sentencing observations when the man appeared before him for sentencing on 12 September 2003. The judge said he had had particular regard to the psychiatric reports. He said the reports did not disclose the existence of any disorder within the meaning of the Mental Health Act but they referred to the difficulties which the man might well experience whilst he was serving his sentence. The judge observed that *"those difficulties have to a certain extent already manifested themselves. Those reports, in my judgment, should accompany you throughout your sentence."*

There is no evidence that the judge's remarks followed the man around the prison system. There was no copy of the remarks in the man's prison record and they were obtained in this investigation only because my investigator asked for a transcript to be prepared.

THE MAN'S TIME IN PRISON

51. The man spent a total of nearly two and a half years in a number of prisons before his death. He arrived at HMP and YOI Forest Bank from Manchester Crown Court on 26 March 2003. A First Reception Healthscreen was conducted on that date and the man said he had no worries about his general health. In the Mental Health section of the reception screen, the man said he had never deliberately harmed himself or attempted suicide. The man was recorded as saying it was not his first time in prison, although in fact it was. The reception screen also incorrectly stated that the man had not been charged with sexual offences. Fortunately, in the additional information section of the form, a more accurate record of the man's situation appears along with a decision that he should be admitted to the Healthcare Centre due to his vulnerability and the fact that it was his first time in prison. On 28 March the man was segregated from other prisoners due to threats that had been made by other men on his wing. Shortly afterwards, on 8 April 2003, the man was transferred to HMP Altcourse in Liverpool.

52. The man was injured on a number of occasions during the time he spent at Altcourse. On 24 April 2003, he was involved in a fight with another prisoner on Reynoldstown Blue, a wing for vulnerable prisoners. After the fight, the Medical Officer noted that the man had redness to the right-side of his neck and a small cut to the right-side of his nose. An Incident Report completed on 3 May 2003 stated that the man was assaulted by another prisoner who threw a cup of boiling water over him. On 12 May, another Incident Report form stated that the man had been fighting with a prisoner on Reynoldstown Blue wing. He sustained a cut lip and said that the other prisoner had punched him.

53. On 18 June, a member of staff completed a Suicide and Self-Harm Communication form because the man was distressed after a visit from his mother. For the next few hours, the man was specially watched at regular intervals by staff. However, by 10am the following morning, he stated that he was feeling much better. He wanted to be removed from the watch and that is what happened.

54. On 27 June, the man was transferred from Altcourse to HMYOI Lancaster Farms. An entry in his Clinical Record on that date noted that he had had diarrhoea in his trousers, though he seemed unconcerned about it. The man showered and his clothes were changed to aid his comfort, hygiene and dignity. He was admitted to the Healthcare Centre at Lancaster Farms for assessment and also due to his vulnerability.

55. On 18 July, the man was discharged from the Healthcare Centre to Coniston Unit, a residential wing at Lancaster Farms. His Clinical Record expressed concern that he might struggle to settle and commented on the possibility that he would be bullied by other prisoners. Healthcare staff had developed a six point plan to help in the transition. Features of this plan included support in areas of hygiene, strategies for dealing with bullying, arrangements to ensure the man was seen daily by nursing staff, that he was to attend ward-based education between Monday and Friday, and liaison with discipline staff.

56. On the very next day, the nurse who had recorded the plan, made a further entry in the man's Clinical Record. She said that the man had been seen on the wing as part of the discharge plan. He had settled in well on his first night, had been out for breakfast with the other prisoners and had attended a chapel service. He had been chatting with the orderlies on the wing and stated that everything was okay with no reported problems.

57. The man was sentenced to six years detention in a Young Offender Institution on 15 September 2003. His Clinical Record states that he was not expecting such a long sentence. On 1 October, there is an impressively lengthy note in the Clinical Record of a visit made to the man on Coniston 1 wing by the nurse who had recorded the plan. Issues highlighted in this note include a programme of care to enable the man to maintain his personal hygiene and to keep his cell clean to a reasonable standard. The man agreed to come to Healthcare for education and to cooperate with staff at all times. He also agreed that he would shower on the hospital unit each day before attending education, and would bring a clean set of clothes over from Coniston Unit with him. The man also agreed to see the Medical Officer for a review of his medication as he was very lethargic during the daytime, and the possibility of reducing his promethazine (an oral antihistamine) was discussed. Wing staff agreed to make bedding and clothing available on a daily basis due to the soiling problem that he had on occasions.

58. Despite the detailed support plan of 1 October to enable the man to remain on residential accommodation, it proved necessary for him to be admitted to the Healthcare Centre as an inpatient on 2 October. The primary admission problems on the admissions sheet were described as his learning disabilities and personal hygiene problems. An inpatient nursing care plan was drawn up the same day. The identified needs at the beginning of the plan were that the man's learning disabilities made it difficult for him to be housed on normal location. His personal hygiene needed monitoring and his social skills were lacking. He was due to be moved to an adult prison as he would be 21 in late November. The desired outcome was that the man would come to terms with being in prison, his level of personal hygiene would become acceptable and he would build appropriate social networks. The care plan added that the man should be housed

on the hospital wing because his *"condition makes him vulnerable to bullying if placed in normal location".* Other parts of the plan spelled out the number of baths and showers the man would have each week, the healthy diet he would be encouraged to eat. (The man agreed that he needed to monitor his weight), and the encouragement he would be given to attend to personal hygiene after using the toilet.

59. The Record of Events section of the man's prison record indicates that he returned to Coniston Unit from the Healthcare Centre on 15 October. However, at lunchtime the same day, he self-harmed by making a noose from a radio lead. The lunchtime patrolling officer had gone to the man's cell when he pressed the cell bell. He noticed that the man had red marks on his neck. The man said he was feeling suicidal and could hear voices in his head. The officer went to get help. When he returned to the cell, the man had tied his radio lead around his wrists and was pulling it. He was readmitted to the Healthcare Centre and the officer opened a Self-Harm at Risk form (F2052SH). The purpose of this form is to ensure that as much help as possible is given to a prisoner during a difficult period when he may be at risk of suicide or self-harm.

60. The man was immediately assessed by the nurse who knew of his learning disabilities and poor coping skills. When the nurse asked the man why he had tied the radio lead around his neck, he said he did not know. The prison doctor saw the man next and decided that he should be admitted to the Healthcare Centre. An informative entry was made in the support record section of F2052SH at 9pm the same evening. The writer had a chat with the man about the day's events and recorded that the man was frightened on the wing. He also mentioned that he thought he would copy a suicide attempt made by another prisoner. The writer counselled the man and explained that this could have gone wrong and had serious consequences for him. The man stated that he would not do it again and was sorry. The entry concludes by noting that the man appeared relaxed and confident back on the Healthcare Centre.

61. A case review was held on 20 October. Its purpose was to share information on how the man was coping and to reach team decisions on what further action needed to be taken. The review was chaired by a different nurse and was also attended by a Senior Prison Officer and a Probation Officer. The review summary stated that the man's case was discussed at length. The team now felt that he was not at risk of self-harm, although he had complex needs which could best be met in the Healthcare Centre. The team decided to close the man's F2052SH because they believed that the risk of self-harm had declined. No further self-harm at risk forms were opened in the two years before the man's death.

62. A second Inpatient Nursing Care Plan was created for the man on 27 October. It stated that he had been admitted to the hospital wing

from reception due to a concern expressed regarding his vulnerability whilst in prison. The desired outcome was for the man to be accurately assessed and to have his needs met with a view to a possible later transfer to normal residential accommodation. The care plan set out four actions that would be taken:

- The man would be placed in an ordinary cell on the Healthcare Centre in order to reduce any risks of assaults by other prisoners;
- A F2052SH would not be opened because the man was *"quite a confident young man, who does not present with any self-harm problems";*
- The man would be allowed time to discuss his concerns on a daily basis with his named nurse or an associated nurse. These counselling sessions would provide an atmosphere of acceptance for the man and give the opportunity for the nurse and the man to discuss progress;
- The man would be encouraged to attend education and gym as soon as possible. The writer said it was fundamentally important for the man to socialise with other prisoners, and exercise was a contributory factor in his physical wellbeing.
- The man remained in the Healthcare Centre at Lancaster Farms from this time until his transfer to HMP Wymott on 7 January 2004.

63. Detailed information about the man's progress and treatment in the Healthcare Centre is contained in the daily nursing notes and in Care Plan Evaluations which were conducted weekly. A particularly useful summary of his conduct and behaviour in the late autumn of 2003 is contained in a report written by his named nurse, on 16 November. They wrote that the man was one of up to ten young men resident in the Healthcare Centre at Lancaster Farms. At times the man's behaviour was childlike and stubborn, and at other times defiant and unhelpful. The nurse said that the man did not present as particularly challenging and was easily managed within the confines of set boundaries.

64. The section on hygiene in the nurse's report noted that the man's personal hygiene was very poor and resulted in nursing staff spending extended periods of time with him in order to ensure a basic level of socially acceptable cleanliness. The nurse noted that the man had a long-standing problem with soiling his clothing and added that *"there may be deeper seated reasons for this behaviour, which will take much specialised work over a number of years to resolve".*

65. The first of the weekly Care Plan Evaluations was completed on 26 October. It stated that the man's major problems appeared to be personal hygiene and bullying issues. The man told the writer that he had no control over his faecal incontinence and revealed that he had

been supplied with incontinence pads when in the community. The plan noted that these should again be given to him, and the next entry on 1 November confirms that he had been given a supply of incontinence pads as required.

66. The entry on 13 December was that the man had been compliant with his hygiene needs. He had adapted well to the hospital environment and his self-esteem and confidence were growing.

67. The entry for 27 December reads:

"Still requiring one-to-one observation and support with general hygiene and cell cleanliness to maintain some level of hygiene. Vulnerability issues continue and depend on what inmates are in his peer group."

68. At this time, the man was asking to be transferred to a prison in Scotland and there are several documents in his record which discuss the option of transfer to HMP Peterhead in North East Scotland. However, the man remained in the English prison system and this appears to have been at his own request.

69. The final Care Plan Evaluation was written on 3 January 2004. It said that the man still required ongoing support to maintain a healthy level of personal hygiene. He continued to reside in the Healthcare Centre.

70. Once the man arrived at Wymott, there is no explicit recognition in his clinical record that he had spent the previous three months as an inpatient in the Healthcare Centre at Lancaster Farms. The first Wymott entry was made on 7 January 2004 and notes that he was not seen by the medical officer (MO). The signature next to the entry is indecipherable. The next entry in the clinical record was made on 20 January and records the man's statement that he was fit and well. The unsigned entry adds that he needed to see an optician. On the same date, an Inmate Medical Risk Assessment report was signed by the doctor. The two pieces of information recorded on the form were that the man was fit to go to the gym and that his labour classification was I which meant that he was not excluded from any work areas.

71. On 13 February, the man complained of insomnia and asked for sleeping tablets. The clinical record states, *"advised that we don't like giving sleeping tablets. He was happy with the answer and left."*

72. On 1 May, a nurse was called to B wing and discovered that the man had a severe laceration to his right upper side lip. The nurse's opinion was that the laceration required deep suturing (stitching) and the man was consequently escorted to a nearby hospital. The hospital's diagnosis was that the man had sustained the laceration after slipping on a wet floor. Three months later, a doctor specialising in plastic surgery wrote to the prison's medical officer informing him

that the scar following suturing of the man's lip laceration had settled very nicely. The plastic surgeon said it would not be necessary for her to see the man again in her clinic.

73. The man's clinical record shows that his weight had dropped to 91 kilograms by the end of November and then to 84 kilos by 13 February 2005.

74. There are two further entries in the man's clinical record before the date of his death. On 23 March 2005, a nurse was called to the man's workshop. He had collapsed, but by the time of the nurse's arrival he was conscious and had no dyspnoea (difficulty in breathing). The man felt hot and clammy and had vomited several times. He stated he was under a lot of stress at work related to his poor performance. He was escorted back to his wing.

75. On 29 June, a nurse wrote of being called to a wing, though the wing was not specified. An elderly prisoner had grabbed the man by the neck and shaken him. No injuries were reported apart from some redness around the man's neck area and the entry ends *"now feels fine".*

THE MAN'S DAILY LIFE AT WYMOTT

76. Residential accommodation for vulnerable prisoners at Wymott is available in A and B Houses, whereas prisoners who are not identified as vulnerable are housed on C, D, E, F, G and H wings. The man was a vulnerable prisoner who spent all of his 21 months at Wymott on either A or B House (mostly referred to as wings by both staff and prisoners). From November 2004 until the time of his death, the man's cell was continuously on B wing, first on B6 landing then on B4 and finally, from 20 June until 14 September 2005, at B3-11. The man was mainly employed in the Weavers' Shop where he cleaned machines and swept up. The man received few visits in prison, with his visits record showing none at all in 2005.

77. Several witnesses told my investigators that the man was exploited and verbally abused by some other prisoners.

78. The man began an intensive Sex Offender Treatment Programme (SOTP) in mid June 2005 and was actively involved with the programme on the day of his death. He was not due to conclude the programme until February 2006. More detailed information about the man's time at Wymott is contained in his prison record and in a series of interviews conducted by my investigators with both staff and prisoners who knew him well.

79. Wymott operates a Personal Officer scheme, with an individual Prison Officer being the Personal Officer for eight prisoners on a designated landing. The same officer is reserve Personal Officer for prisoners in a further eight cells. Many of the entries in the man's wing file (F2052A, Record of Events) are made by different officers who acted as his Personal Officer, although of course there are entries made by many other officers also. The first entry in the record on 9 January 2004 referred to his learning difficulties, but observed that he could communicate very well if given the time to compose himself. Staff were advised to be aware that he was vulnerable and *"maybe susceptible to bullying".* On 26 January, during his first Personal Officer interview, the man completely denied that he had committed any sexual offences. An entry on 2 May states that he injured his upper lip after falling whilst cleaning his cell. A Senior Officer spoke to the man about the injury. The man assured him that nothing sinister had occurred and that the cause of the injury was genuine.

80. An entry on 7 June referred to an application for a move to a Scottish prison. The man was told that Peterhead was the only Scottish prison that accepted vulnerable prisoners. The man was not willing to move to Peterhead and said that now he would like to remain at Wymott.

81. In October 2004, the man told his then Personal Officer who was also an experienced SOTP facilitator (tutor), that he was willing to join the SOTP.

82. On 20 March 2005, an officer wrote after a Personal Officer interview with the man that he had completed the Extended Enhanced Thinking Skills (ETS) programme.

83. According to the man's prison record, another five months passed before his next Personal Officer interview was held on 29 August. On 20 June, the man moved from B4 landing to B3-11 and another officer became his Personal Officer at that point. There are many references in the man's record to the untidiness of his cell and on 13 August an officer who was a former nurse, wrote that she had found the man's cell in a dirty state. She told him that if it was not cleaned over the weekend he would be on Basic on Monday. (This was a reference to reducing the man's privileges on the National Incentives and Earned Privileges Scheme to the Basic (lowest) level.) Another officer made an entry on 15 August to say that she had checked the cell and found it much cleaner, but warned the man about any future decline. The next entry in the record on 17 August was again made by the same Officer. She referred to the interception of a letter that the man had written to his social worker. He told his social worker that he had self-harmed. The man told the officer that the self-harm was a very superficial scratch on his forearm which he had done several days previously. He said that several staff were already aware of it and that it was a *"one off"* because he did not feel suicidal.

84. My investigators interviewed the officer about the entries she had made in the wing file. She had brought the man into the office and chatted to him about the letter to his social worker. When she asked the man about self-harm, he rolled up his sleeve and showed her his forearm. It was clear to the officer that the injury was several days old *"because it had scabbed over, it was very superficial, it didn't need a dressing on it".* The officer asked the man why he had done it and remembered him saying that it was because he was doing the SOTP and that the SOTP tutors were aware of what he had done. The officer said in interview that she wondered whether the man had some sort of learning difficulties because he always walked about very slowly, and was always very grubby looking despite being encouraged with his personal hygiene. She recalled that he walked around with his shoe laces undone and his shoulders hunched.

85. The next entry in the man's wing file was made by an officer on 29 August after his Personal Officer interview with the man. He recorded that he had been unable to write a report in July due to his annual leave and night duties. He noted that the man still had problems with his hygiene and cleanliness, even though other prisoners on the landing were trying to help him. The man told the officer that he would try harder. The officer recorded that he was attending the SOTP *"and appears to be coping".*

86. My investigators interviewed the officer,and discovered that he was a very experienced officer who has worked at Wymott for the last 20 years. The officer described the man as a man with many problems. He was very immature and was a difficult person to relate to because he seemed to keep himself to himself in a lot of ways, and was not willing to open himself up to other people. The officer knew that a couple of prisoners on the man's spur were willing to assist him and tell him what he needed to do *"and talking to him and if he was low at any time just try to buck his spirits up".* The officer realised that the SOTP was causing the man problems. In interview, and with the benefit of hindsight after the man's death, the officer said that:

"he was finding difficulty in accepting and once he had been actually made to think about what he had done, to accept that he had actually done that and it seemed to be on his mind and that was making him more and more depressed and withdrawn."

87. The officer felt that there were two sides to the man's participation in SOTP. On the one hand, he was getting something out of the programme because it made him think about what had happened and gave him an incentive to go one step further. On the other hand, *"he got more and more involved in what was happening and having to tell the people what he had done, he went down and the two lads seemed to be spending more time actually talking with him and trying to bring his spirits up".*

88. The officer spoke of the man's incontinence coming to light after his death. The officer was not sure whether the bowel problems were a rumour or the truth. He added:

"… if that was the case, it would explain a lot of the problems we had with him and perhaps if we had been aware of that at an earlier time, we would have understood more about what was going on."

89. When speaking in greater detail about his wing file reference to hygiene and cleanliness on 29 August, the officer recalled that there were a couple of times when wing staff found faeces in the man's cell. There was another occasion where the man put his kit or clothing to the wing laundry to be washed and there was a smell. When the kit was taken out, wing staff found that it was full of faeces. There is no indication that healthcare staff were consulted at the time.

90. My investigators asked the Officer about the man's behaviour in the two weeks of September before his death. The officer recollected that the man *"seemed quite cheerful, talkative, laughing, little pranks which is what he was good at doing. He did seem a lot better. I think this [his death] actually came a little bit out of the blue."* With the assistance of his friends, the man was keeping his cell reasonably tidy and seemed to the officer to be coping a lot better.

91. My investigators asked the officer about the man's relationship with the other men on his spur. The officer said that prisoners did pick on him, referring to his personal hygiene and *"just telling him about how dirty he was and intimidating with remarks"*. The officer was not aware that the man had been physically intimidated since his arrival on the 3s landing. However, he spoke of being told that the man had been assaulted and picked on and actually hit on a couple of occasions during the six weeks he spent on the 4s landing before his transfer to B3-11.

92. The officer said he was very surprised when he heard that the man had committed suicide (the officer's expression) because the man seemed to have been much improved and less depressed. When asked about any recommendations he would like to make, he said that he did not think that the man should have been at Wymott: *"I don't think we have the facilities he required due to his mental state, his lack of education; I think he needed more attention and we were not able to give him that."* In a later answer, the officer said he did not think that Wymott had the facilities, the time or perhaps the professional people within the prison who could have helped the man.

93. The prisoner at Wymott who knew most about the man was the older prisoner. He was the man's prisoner supervisor in the Weavers' Shop and, during the last few months of his life, the man was housed just across the landing from him. In interview, the older prisoner recollected that he first met the man on A wing in January 2004 when the man arrived at Wymott. He added it was quite clear after several days that. *"the boy could not really take care of himself … First of all we had a job in teaching him how to put his shoes on, on the correct feet and how to start tidying his cell."* The older prisoner did his utmost to care for the man and to give him practical help with his daily life at Wymott.

94. The older prisoner said that the man had a very difficult life in the prison because he had bowel troubles and many prisoners on the wing called him smelly. He added several times that the man was like a boy of 13 in a man's world. Prisoners took advantage of the man, according to the older prisoner, and then he got into debt. The older prisoner stated that there were one or two prisoners who did not really understand the man and they used to hit him. The older prisoner indicated that he put a stop to that and recalled that the man took a few bangs to the head from other prisoners. The older man said the blows were to the side of his jaw and his forehead in the smokers' room of the Weavers' Shop.

95. The older prisoner knew that the man was in debt to several prisoners at the time of his death. He said the debt was 27 Mars Bars which the man owed to about five different prisoners. The older prisoner said the prisoners were reluctant to receive payment after the man's death, but he insisted on cancelling the debt.

96. The geography of the spurs at Wymott meant that the man had unlimited opportunities to talk to the older prisoner, especially once the staff had gone off duty at the end of each evening. There is a locked gate at the top of the corridor leading to each spur in the prison, but within the confines of the spur prisoners have free movement and they also possess a key for their own cell door. He explained that the only time the man would talk to him about his personal problems was in the evening because then the man could go into his older friend's cell on his own. He recollected how the man would come into his cell at teatime and say that he had to talk to him later. He would never do so until the door at the end of the corridor was locked, and the staff had gone home for the night.

97. The older prisoner spoke very matter-of-factly about the practical assistance he gave to the man. When he first saw that the man's shoes were on the wrong feet, he would tell him to take his shoes off and then put them back on again. They went through this procedure for quite a period of time *"but eventually he got the knack, then it would be very rare you would see him with his shoes on the wrong feet".*

98. As soon as the interview with my investigators began, the older prisoner referred to the man's bowel troubles. He explained that, after lock-up in the evening, prisoners only have access to one night toilet on the landing and they do not have access to showers. The older prisoner said that, *"if he was unfortunate and had an accident at that time, well we had to try to use our own methods as best we could. After his death, someone said that it [his bowel problem] was not even entered on his medical record. This could be a possibility because several times I would have to give him fresh underclothes out of my own allocation. Fortunately, I could manage because I was not ill."*

99. Towards the end of the interview, the older prisoner was asked to speak about the man's bowel problem in more detail. He said that, in normal circumstances, if somebody has bowel troubles he is given a mix of clothing and underclothes and the necessary bags to put his stuff in. The man never had any of these. The older prisoner used to give him some of his own clean clothes. He encouraged the man to seek help for the problem himself because he felt it was no good if he did everything for his friend, and he wanted the man to become self-sufficient. The older prisoner used unofficial, as well as official, means to try to preserve the man's dignity. He sometimes asked prisoners working in the stores to make additional sets of underclothes available to him for the man's benefit.

100. The older prisoner was very critical of the SOTP course and felt it should be scrapped. He said that the man was a 13 year old boy who was being mentally "hammered" by some of the other prisoners on the course. The older prisoner claimed that the man slowly got more and jittery as the course was going on, because he knew it was

coming closer and closer to the time when he must speak about the circumstances of his offences. The older prisoner was not aware that the man was to be on the 'hot spot' (as the older prisoner called it) on the day of his death, and the older man was strongly of the view that the man should have received treatment on a one-to-one basis rather than in a group environment.

101. The man's next door neighbour, in Cell B3-10, was another prisoner who felt that the man was very confused, quite emotionally unbalanced and needed a lot of help. The neighbour said that a number of prisoners tried to wind him up and called him names. They did not know the extent of his toiletry problems so they called him smelly.

102. The man's neighbour, said he was very insecure and needed a lot of cuddles. He confirmed that the man was in debt at the time of his death and that he had made up a list in preparation to pay the debts off. He stated that he and the older prisoner had discussed the matter at length with the man. He felt that the man made *"the most ludicrous bets, knowing full well that he would lose, maybe just to gain a bit of attention, to gain people's affection".*

103. My investigators asked the neighbour about the man's behaviour in the days and weeks leading up to his death. He felt his behaviour had changed slightly, that he had become a little rowdy and he was seeking attention a lot more. The neighbour said he was quite *"down, he voiced concerns about the SOTP course that he was attending and he was quite down about that and really didn't look forward to going into any of his course days".* When he was reflecting at the end of his interview the neighbour said that prisons are one size fits all, which doesn't work, *"it should be judged on individuals rather than inmates collectively. Everyone should be looked after individually. I think somebody like the man with mental health issues really shouldn't have been in prison in the first place, he needed care. He didn't need to be put in here to be made ten times worse."*

104. Two prisoners who were attending the same SOTP course as the man asked to see my investigators. One said, in a striking phrase, that the man was *"tormented by a lot of inmates"* when he first arrived at Wymott. He was asked what form the torment took and said he saw the man having his trousers pulled down in front of everybody. He added that the man was called names and he alleged that some officers laughed at him.

105. The second prisoner said that sometimes the man had to be told to pull his trousers up because they were around his ankles. He said that the man was *"like a young kid"* who could not tie a knot and could not even tie his own shoe lace. He suggested the investigators should look at the question of whether the man killed himself or whether he was helped.

106. A third prisoner spoke to my investigator just before being released at the end of his sentence. He felt he had information about what might have caused the man's death. He spoke of a man on the wing who was *"taking coffee, biscuits, tea and sugar off the man. As he was a bit slow in certain things, this bloke pestered him and he [the man] did hand the stuff over."* The man in question was on I wing, a unit for elderly prisoners, along with the third prisoner. The third prisoner said he spoke to Mr W, the man allegedly pestering the man, and told him to stop. He said that Mr W did stop but then in the last couple of months before the man's death it started up again. The man's motivation for handing over items he had purchased in the canteen to Mr W seems to have been the mistaken belief that Mr W would help him to move from B House onto I wing. The third prisoner explained to the man that he had no chance of moving onto I wing and that Mr W was robbing him.

14 SEPTEMBER 2005

107. The Adapted Sex Offender Treatment Programme (ASOTP) consists of 13 blocks, and by the morning of 14 September the man and the seven other prisoners in the group had reached block 7, which is called 'My Offence'. The treatment manual for the programme explains that during the sessions in this block each group member has to go through his offence. Other members of the group will ask a lot of questions. The facilitators will be looking for individual prisoners *"to give an account which describes 'how you made the offence happen'".* The manual states quite clearly that:

"Most people find this difficult at first. It takes a lot of courage to be honest about what you have done. Learning to take responsibility is the first real step towards not reoffending".

108. One of the facilitators wrote an account of the events of the morning. The programme that day began at 9.15am with all group members, except one, present. The session was No. 37 in the programme. The first half of the session focussed on the offence account of another prisoner. There was a coffee break at 10.20am and then the session resumed at 10.40am with the man giving his offence account.

109. To the surprise of the facilitators, the man was very forthcoming in relating the details of his offence. He had always been open in giving details about his offence, but the facilitators felt he was particularly honest in disclosing some very sensitive information on this occasion. Fellow prisoners were invited to ask questions, but few did so since the man was doing most of the work without any need for prompting. Both facilitators wrote that the man seemed generally relaxed in giving his account, even when disclosing sensitive information.

110. The session ended at 11.35am. The man was praised by group members and facilitators for his efforts. He was asked if he would be willing to resume his account for 20 minutes at the start of the next session (there is just one session each day) and he said he was very willing to do this.

111. A fellow course member said in interview that the man was very truthful on 14 September about his offence. He added, *"I think he was more revealing than he had ever been and my own opinion was that he wanted to get it all out there and then. But I think the stress of the course didn't help him."*

112. The fellow course member added that, being asked about the circumstances of your offence by another prisoner, *"was horrendous to go through. In my opinion it is worse than being interrogated by the police and that's how bad it was."* He felt that the man had done

very well to give his account in the way he did: *"I admired him for bringing it all out as he did."*

113. After the other group members had left the group room, the man came to see one of the facilitators and told her that his bowel problem was getting worse. He said that he wanted to tell the group so that they would understand his problem. She advised him to think about the issue overnight and give it careful thought before he told the group. He repeated that he wanted to tell his fellow group members and that he felt comfortable in doing so. The facilitator told him that if he still wanted to tell the other prisoners in the morning he would be allowed some time to do so before the session began. This was the last time that she saw or spoke to the man.

114. In her statement about 14 September, the facilitator also mentioned a discussion with the man which had taken place several weeks earlier. The man showed the officer a letter stating that his friend had been moved to another wing. The man missed talking to him. The next day the man came to see her again and said he had been advised by another prisoner to tell someone that he had self-harmed. She asked him why and he told her that it was because his friend had been moved. He also told her he had harmed himself six days previously. She looked at his arm and noticed a few superficial scratches. He said that he did not wish to be placed on F2052SH and that the desire to self-harm was no longer present.

115. The facilitator immediately went to speak to a Senior Officer (SO) on B House. She told him that she did not consider the man to be a risk to himself at that time. This was because the injuries had been inflicted six days previously and *"the reason for them was linked to getting a prisoner back on to the same spur as the man".* The SO said he trusted the facilitator's judgment and was happy not to open a Self-Harm at Risk form. She returned to speak to the man and informed him that his friend could not be moved back on to the wing. The man said *"he understood and was fine with this. He reiterated that he no longer felt like self-harming and I obtained an agreement from him that if he experienced any further problems or he felt depressed in any way to come and speak to one of the facilitators as soon as possible."*

116. On the morning of 14 September, a regular officer (Officer A) on B3 landing but not the man's Personal Officer received two pieces of information about the man. Some prisoners from B3 landing complained about the smell coming from the man's cell and he answered a telephone call from the instructor in the man's workshop. The older prisoner had told the instructor about the size of the man's debt and the instructor was sufficiently concerned to ring staff on the man's wing. Officer A decided he would keep the man back from work during the afternoon so that he could talk to him about the two separate matters that had just come to his attention.

117. The man's next door neighbour saw him at lunchtime after he had returned to the landing from his ASOTP course. When asked how the man seemed to be, the neighbour replied:

"His behaviour was pretty much like the man's, quite consistently inconsistent really. One minute he was quite jovial and happy and the next minute he was quite down."

The neighbour added that another prisoner had upset the man after his course and the neighbour had also heard that *"an inmate had threatened to stab him in the workshop or something".*

118. Officer A did indeed speak to the man on the afternoon of 14 September. He estimated that their conversation lasted for about 15 minutes. The man readily told him that he had a bowel problem and about the debts that he owed. The Officer responded energetically to the man's disclosure about his bowel problem. He rang the Healthcare Centre to find out if they already knew. In interview, Officer A said that the lady in HCC to whom he spoke got the man's medical record out. He thought she must be a member of the administrative staff in HCC because she could see no reference to a bowel problem in the record but said that one of the nurses would call the man back. He also rang the clothing exchange store to find out the prison's policy on help with incontinent prisoners. Officer A has been an officer for 15 years and was well aware that I wing at Wymott holds a number of elderly men, some of whom might also be incontinent. Later in the afternoon, his colleague in the clothing store sent over additional items of kit for the man to use in response to the Officer's initiative.

119. The last person to see the man alive appears to have been his neighbour. In interview, he estimated that he last saw the man at 3.30pm. At that time, he complained to the man who was playing a song at full blast on his stereo. He knocked on the man's cell door, they had a bit of a laugh together and a playful exchange, and then the neighbour went back to his cell and carried on with his upper body exercises.

120. At 4.10pm, the neighbour looked into the man's cell and saw him hanging from the bars on the window. The neighbour asked another prisoner who was on the spur to come and verify what he was seeing, and then the prisoners pressed the alarm bell situated towards the gates at the end of the spur.

121. The first officer to reach the man's cell in response to the alarm call was Officer B. In interview, he explained that he was the cleaning officer on B wing on the afternoon of the man's death. He said that, when a prisoner presses the alarm call bell on the landing, a light lights up in every wing office and also in the Senior Officer's office on B House so that staff can determine from which landing the call has been made. Officer B was sitting with some colleagues in the 1s and

4s wing office, which is on the same level as the man's cell but at the opposite end of the wing. Staff told my investigators that it was quite rare for the alarm bell to sound during the afternoon, so they responded rapidly when the panel in their office lit up to indicate a possible problem on B3 landing. Officer B thought that the time when the emergency began was approximately 4.10pm because he was talking with his colleagues just shortly before going for his tea at 4.15pm. At the time, the majority of prisoners were still at work, but there are always some other prisoners on the landings who either work as cleaners or who have not gone to their normal jobs for a variety of reasons.

122. When Officer B entered the man's cell he saw him hanging by his neck from the cell bars. The bars were at the rear of the cell as he looked in at the doorway. Straightaway, Officer B could see a ligature around the man's neck. It appeared to him to be the blue belt of a terylene dressing gown. The man was facing the door of the cell and his feet were off the floor. Other Officers were immediately behind Officer B. He climbed onto a table beside the man and tried to remove the ligature from around his neck, while the other Officers supported the man's weight. Officers at Wymott do not carry ligature knives and Officer B said in interview:

"We had a struggle to undo the knot initially, because of the man's weight. We changed round, I supported some of the weight and a second officer undid the first of two knots and the second knot was harder to remove. I removed that and then we placed the man on the bed."

123. Officer A ran to the landing office to obtain a set of scissors or a blade to assist his colleagues. He also rang Wymott's Control Room and asked for immediate healthcare assistance for a Code Blue (hanging) emergency on B3 landing. All three officers indicated in their statements to the Governor that supporting the weight of the man's body before the ligature could be removed was physically very difficult indeed. The man was described by the detective who led the police investigation as a stocky prisoner. The third Officer wrote how he and the second Officer struggled to lift the man higher so that the Officer B could undo the second knot.

124. The Control Room Daily Log Sheet contains no significant entries on 14 September until 4.13pm when a phone call was made from B wing to say that a prisoner was hanging. The Healthcare Centre was informed at that time. At 4.14pm, the log sheet shows that the Control Room received a Code Blue urgent message and at the same time a nurse (H3) was on her way to the emergency. At 4.15pm, the Control Room received a call to say that an ambulance was required. The Control Room duly requested an ambulance and was told that two vehicles were en route.

125. The first attempts to revive the man were made by Officer B. He attempted to clear the man's airway by tilting his head back so that his tongue was not obstructing. He then started chest compressions, although he thought that the man was already dead. He recalled that his eyes were staring, there was no movement at all and there was froth around his lips. In interview, Officer B remembered that a nurse seemed to appear on the scene almost straightaway. The third Officer helped healthcare staff by bringing their Code Blue bag from the medication room and the Officer B assisted the nurse in the cell while she gave the man oxygen.

126. Two Nurses made a joint entry in the man's clinical record. (I observe, in passing, that it would have been preferable for the nurses to make an entry each, in order to acknowledge their individual accountability.) They wrote that they arrived on the wing at 4.15pm and found the man where wing staff had placed him on his bed. There were no signs of life, they could feel no carotid pulse and he was cyanosed. (Cyanosis is a medical term meaning a bluish discoloration of the skin due to inadequate oxygenation of the blood.) The man's pupils were fixed and dilated. They began airway management and cardiopulmonary resuscitation (CPR). Officer B's description of this part of the rescue attempt is that the nurse was giving alternate mouth-to-mouth and chest compressions to the man.

127. The nurses wrote that a defibrillator was connected to the man. (This is a piece of equipment with the ability to administer an electric shock to a patient's heart in a bid to restart it.) The machine advised the nurses that the man should not be shocked. They continued with CPR in response to instructions from the defibrillator until paramedics arrived at the cell. At 4.35pm, a joint decision was made by the nurses and paramedics to discontinue resuscitation attempts.

128. The Control Room log states that at 4.22pm a message was received from B wing to say that the man was receiving CPR but there were no respiratory signs. At 4.24pm, the first ambulance arrived at the prison and at 4.26pm a second ambulance arrived. At 4.27pm, first response personnel arrived at B wing and the log then records a message from a Principal Officer at 4.32pm to say that the man had died.

129. The last part of the nurses' entry in the clinical record states that a doctor was contacted but was unable to attend in order to confirm formally that the man had died. Another doctor was then contacted and said that he would attend the prison at approximately 6.30pm following his surgery. The last entry in the man's clinical record was made by the second doctor. He wrote that he attended at the cell at 6.45pm and confirmed the man's death at 6.51pm.

130. The man's mother and grandmother live in a town hundreds of miles to the north. Prison Service Order 2710 on Follow-up to Deaths in Custody states that the news of a prisoner's death should be

conveyed in person by a visit to the next of kin unless it is inappropriate for geographical reasons. In this case, it was clearly not feasible to break the news of the man's death in person due to the extremely long journey that would have been involved. The prison therefore liaised with the local police force in Scotland and asked them to pass the news of the man's death to his next of kin.

131. In May 2005, the man had applied for his grandmother to be recognised as his next of kin. The man's prison record states that an application was sent to Custody Admin on 3 May 2005 for his next of kin details to be changed from his mother to his grandmother. There is no further entry on the record to say what happened to the man's application. The necessary alteration appears to have been made at this time to the prison's computer record on the Local Inmate Database System (LIDS). However, no manual change was made to the first page of the man's core prison record which continued at the time of his death to show his mother at her own address as the man's next of kin.

132. The duty governor on the evening of the man's death told my investigator that he had considerable problems in making contact with the man's next of kin. He eventually managed to make telephone contact with the man's grandfather and the man's grandmother was also at home at the time. They made their way to the home of their daughter (the man's mother) but, by the time they arrived, the news of the man's death had already been broken to her by a local police officer. Scottish police records show that Lancashire Constabulary made contact with them at 7.51 pm on 14 September. Three minutes later, the message was passed to a local police officer to deal with. It is extremely unfortunate that the man's mother, who is herself a vulnerable woman, did not receive the shocking news of her son's death from her own parents but from a policeman.

133. My investigator has discussed the man's 3 May application to change his next of kin details with the Executive Officer in charge of the Custody Office at Wymott. She told him that prisoner requests to change next of kin details are very rare indeed, with requests to change religious affiliation being more common. When an emergency arises, it is clearly essential that making contact with a prisoner's nominated next of kin can be done speedily and straightforwardly.

I recommend that the Governor reviews what happened after the man's next of kin application of 3 May with a view to devising a system that is efficient, reliable and as un-bureaucratic as possible.

134. The arrangements for giving support to staff and prisoners after the man's death were very good. An important report on the aftermath has been supplied to me by the Chairman of the Independent Monitoring Board (IMB) for Wymott. (Each prison has an IMB

composed of local people, appointed by the Home Secretary, whose task is to monitor the treatment of prisoners and the performance of the prison.) The chairman's report is an objective and credible document because of his independence from the Prison Service, and I am most grateful to him. He has written that he received news of the man's death at 4.45pm. By 5pm, he had arrived at the prison. At 5.15pm, he accompanied a Residential Governor, who visited each of the landings on B wing to let prisoners and staff know what had happened. The chairman has recorded: *"He handled this sensitively in an open but discreet manner … He advised prisoners of the arrangements for additional chaplaincy and staff presence during evening association; there was a good response from prisoners."* After 6pm, the chairman's report indicates that wing staff organised the serving of the evening meal as normal. There followed normal evening association (when prisoners are permitted to mix with each other outside their cells) with appropriate restrictions on movement in the vicinity of the 3s landing.

135. The chairman's overall assessment at the conclusion of his report is as follows:

"From my observations, the staff who were directly involved in the incident and other wing staff responded sensitively and professionally both to the requirements of the situation and to the needs of the other prisoners on the wing."

136. Since June 2005, there had been seven other prisoners on the ASOTP group that the man had been attending. Detailed and sensitive plans were drawn up to decide how the group of both prisoners and staff should respond to the shocking event of his death.

137. On the morning after the man's death, the Head of Psychology and Programmes at Wymott, and a Senior Officer (Programmes Manager) arranged to meet with three facilitators on the group in order to provide support and to decide on the appropriate action for group members. During the meeting, the three facilitators had an opportunity to discuss what had happened and their responses to the news. The three facilitators met with the group members on the afternoon of 15 September and it was also agreed that the normal session of the group would take place on Monday 19 September.

138. The statement written by one of the facilitators explains that the purpose of the meeting was to give all the group members an opportunity to talk about the man's death the previous day. The senior officer opened the meeting by telling the group exactly what had happened from the moment the man was discovered hanging in his cell, through to the removal of his body by undertakers at approximately 7.45pm in the evening. The remainder of the afternoon was spent by inviting everyone, including the facilitators, to speak about how they felt regarding the man's death.

CLINICAL REVIEW CARRIED OUT BY HEAD OF SERVICE DEVELOPMENT AT THE PCT

139. I am most obliged to the Head of Service Development at Chorley and South Ribble PCT for carrying out a comprehensive review of the clinical care received by the man at Wymott and at other prisons. He concludes that the man was a very vulnerable individual. He notes that his vulnerability was further compounded by his apparent learning disability and possible mental health condition, although the latter was not confirmed. The clinical reviewer comments favourably on the lengths to which nursing staff at Lancaster Farms went in order to ensure that the man's level of vulnerability was reduced. He praises particularly the detailed Nursing Care Plans which were developed and agreed. However, he is concerned that recognition of the man's vulnerable nature was not picked up at Wymott. He states that, *"there is no apparent recognition in the IMR following transfer to Wymott of the level of input that had been provided by the healthcare team at Lancaster Farms".* The reviewer is particularly forthright when commenting on the quality of record keeping that he encountered in reviewing the case. He states that the Inmate Medical Record (IMR) is difficult to follow, with notes and reports filed in what can only be described as a chaotic manner and out of sequence. He adds that entries are often illegible and signatures are indecipherable. It is very often impossible to ascertain to which prison a particular form or entry relates as this is not identified on the form.

140. The reviewer includes a page on confidentiality in his review. He observes that the overriding principle in relation to confidentiality outside the prison environment is that of a *"need to know basis".* He explains that the issue of confidentiality is not as clear when it comes to the passing of information within the prison setting. He suggests that further work should be undertaken on a national basis to examine the issues relating to confidentiality within the prison system.

141. The reviewer makes four sets of recommendations at the end of his review. In relation to care planning, he notes that the process of care planning at Wymott appears to be basic and to lack a clear systematic approach. He recommends that a Senior Nurse be responsible for the review of care plans and that minimum standards for the completion of care plans be implemented and reviewed on a regular basis.

142. In relation to the inadequate record keeping the clinical reviewer encountered during the process of his review, the recommendations he makes are:

- all entries to the IMR should be signed and dated with a signature printed overleaf;
- the record should include all relevant Prescription and Administration Record Charts with a note being made if a drug is not administered;
- all prison pre-printed documentation should include space for the prison to identify itself on the form;
- The quality of records should be subject to regular review and audit, in line with current best practice and professional standards.

143. In relation to risk assessment, the reviewer writes that there is no evidence of a system of assessment of prisoners at risk upon arrival at HMP Wymott. He recommends that:

- a comprehensive mental health risk assessment of all vulnerable prisoners should be implemented at Wymott;
- a policy for the proactive follow-up of vulnerable at risk prisoners should also be developed.

144. In relation to confidentiality, the reviewer recommends that a review of confidentiality within Prison Healthcare should be undertaken, with a particular and initial emphasis on those prisons providing SOTP.

145. I endorse all of the recommendations made by the reviewer.

THE ADAPTED SEX OFFENDER TREATMENT PROGRAMME

146. A central element in my investigation has been to examine whether there was any link between the man's involvement in ASOTP and his death. My investigator has read the 78 page Treatment Manual for ASOTP, which was issued in 2003 by the Offending Behaviour Programmes Unit (OBPU) at Prison Service Headquarters. Early pages of the manual explain that one of the main goals of the course is that *"low intellectually and socially functioning sex offenders"* should move from Old Me to New Me. 'Old Me' is the person they were when they offended; 'New Me' is the person they are working towards being, their ideal (but realistic) self. The programme is divided into 14 blocks and a total of 89 sessions, each lasting for two hours. Most of the blocks consist of just a few sessions, but there are two blocks which are very much longer than any other. Block 7, entitled My Offence, lasts for 32 sessions. Block 13, just before the end of the course, lasts for 25 sessions and is entitled Introducing 'New Me' Tactics. There is a review in the middle of the programme and a case conference at the end of the group, but the man's death came before either of those events.

147. The section of the manual dealing with Block 7, My Offence, stipulates that each group member should have approximately three sessions in the 'Hot Seat' where he has to give an active account of the circumstances of his offence or offences. Page 41 of the manual refers to this as a stressful block and the facilitator's notes at the end of the block say it is *"extremely stressful and demanding; most of them [the prisoners] will find it very difficult".*

148. Before the man attended ASOTP, he had already completed an ETS programme in February 2005. This programme consists of 21 two-hour sessions and is based on the premise that an individual's ability to achieve goals in a pro-social (rather than anti-social) manner is improved by developing thinking skills. My investigator has examined the post-programme progress review written on 18 March 2005 after the man had completed ETS. The Summary of Progress section at the beginning of the Progress Review commences thus:

"In preparing to write this report and therefore gathering information in respect of the man, it has come to light that he experiences a number of learning and developmental difficulties which we were unaware of prior to his commencement of the course."

149. Section 2 of the report states that: *"The man's seemingly erratic contributions [to the course] appear to be systematic [(sic) I assume this is a misprint for symptomatic] of his condition. Unfortunately tutors did not have access to this information until after the course was completed."*

150. The last part of Section 2 covers the application of skills learned on the course to real life situations. The review's conclusion is:

"… in the light of new information as detailed above, tutors are unable to give an informed opinion regarding the man's level of understanding and application of skills. It would appear that further intensive work tailored to meet the man's individual needs would be more appropriate."

151. Section 3 is the final section of this review and lists recommendations for the further development of skills. The recommendation of staff attending the review was to:

"Formulate a care plan through a case conference to include multi-disciplinary professionals in order to address the man's outstanding needs whilst in prison and upon release. Case conference to be held within four weeks of the date of this report."

152. I have been unable to find evidence that this recommendation was heeded or actioned as the man was considered shortly afterwards for participation in ASOTP. The document does not indicate that recommendations and action points made at the review were to be implemented by a named person or persons.

I recommend to the Governor that the action plans and recommendations drawn up at reviews of offending behaviour programmes should clearly indicate who is accountable for implementing them.

153. At an early stage in this investigation, I decided to obtain expert answers to a number of questions about the man's involvement in ASOTP from the highly qualified psychologist who is the Head of the Sex Offender Treatment Programme at the OBPU. I am most grateful to her for the detailed and candid information she has given to my investigators at various stages of this inquiry. My investigator wrote to her on 4 October and she replied to all the questions in that letter on 14 October.

154. The psychologist was asked to comment on whether decisions taken at all stages of the assessment and course delivery process were in accordance with the arrangements set out in the SOTP manual. She concluded that the decisions about the man were in accordance with published standards. The man was fully assessed for intellectual functioning and he signed all the relevant forms, such as consent forms. Medical clearance was obtained in the usual way for SOTP. The group was run by fully trained and experienced facilitators and had an experienced supervisor. There is evidence, according to the psychologist that at least some information about the man's medical and mental health was available to the facilitators. The psychologist believes that best practice would additionally have included a fuller account of the man's medical history, including a more detailed

account of the symptoms associated with FACS and information about the support plans that had been in place for him prior to coming to Wymott. Ideally, a care and support plan would have been agreed with residential and healthcare staff.

155. The second question answered by the psychologist was whether the man should have been selected for ASOTP. She noted that the majority of reports recommended ASOTP for him or referred to ASOTP without any comment on suitability.

156. The psychologist thought that the decision to select the man for ASOTP was reasonable in the light of the information available. She said that: *"in the same position, I would have made the same decision".* However, she referred to the man's needs outside the group and added, *"He was not receiving the level of professional day-to-day support he was used to and obviously needed".*

157. The third question answered by the psychologist was whether the facilitators and their supervisor were aware of any misgivings about the man's participation in SOTP. She said it would be important to discuss whether the facilitators communicated the following information to their supervisor:

- that the man asked on several occasions to come off the group (including by written note to his facilitators and verbally, as recorded in his treatment diary);
- that the man told several people he found the group *"very hard";*
- that the man told one of the facilitators that he had self-harmed.

158. The fourth question answered by the psychologist was whether the Healthcare Centre at Wymott had disclosed sufficient information about the man's medical condition before he began ASOTP. The psychologist wrote that the procedure followed in the man's case was in accordance with current national SOTP standards. A form was submitted to the medical centre. However, the psychologist criticised the fact that the date on the form was several months after the start of the course as *"not acceptable"*. She said that medical clearance should be obtained before a prisoner starts a course. I agree entirely.

159. The psychologist thought that some additional information was available to the facilitators. She referred to the Progress Log containing a short paragraph about the man's diagnosis of dyspraxia and the symptoms he had associated with FACS.

160. The psychologist was asked to comment on whether the arrangements for supporting the man at the time he disclosed his decision chain (the circumstances of his offences) were adequate. She wrote that, with the benefit of hindsight, there were some indicators that additional support would have been helpful for the man. These indicators included:

- The fact that the man had historically received very high levels of personal support in his home town from carers in simple day-to-day living.

- The fact that the man had communicated to facilitators that he found the group hard, wanted to come off the group and that he had self-harmed.

- The psychologist wrote that the SOTP was clearly going to be a demanding enterprise in relation to the man's life experience and therefore it would have been appropriate to consider that he might need some back-up support on a regular basis throughout the programme

161. The psychologist noted that the man's presentation in the session on the morning of his death did not show signs of depression or distress. In her view, the man spoke in a reasonably confident and forthcoming way about the lead-up to his offence. He readily agreed to continue talking about the offence at the beginning of the next day. The psychologist wrote: *"there is nothing about his presentation in the session to indicate depression or suicidal intentions".*

162. Both the psychologist and my investigator have watched a videotape of the session on the morning of 14 September where the man spoke about his offences. The psychologist is therefore able to say in her letter:

"I would like to stress that the session itself was run in a cheerful and relaxed manner. There was no question that the man was badgered or put under pressure by the facilitators or other group members. He appeared comfortable talking about his offence and responding to their questions. There are no moments of tension and the facilitators' therapeutic style is warm and encouraging towards the man."

163. My investigator shares the psychologist's view about the videotape. There are no signs on the tape that the man was in acute or undue distress, or that he was contemplating a major act of self-harm just a few hours later.

164. In the final section of her letter, the psychologist commented on whether any changes should be made to delivery of SOTP locally or nationally. She considered that there were two areas where delivery of SOTP could be adjusted. The first is the communication system between health and psychology departments about a prisoner's suitability for treatment. She felt that the medical clearance form might be inadequate both in content and in process.

165. In this man's case, the system for obtaining medical clearance was that an exchange of forms took place between the Psychology and Healthcare departments. A standard pro forma, headed Sex Offender Treatment Programme, was sent from a Psychology

Assistant, to Healthcare on 6 September 2005 (the assistant had taken up her post just a month previously). The form was not addressed to a particular person in the Healthcare Centre, but explained that eight prisoners were possible candidates for the SOTP. It added that prisoners in five categories could not be selected. The categories were 1 – an acute psychotic illness now or at the time of the offence, 2 – those suffering from paranoid personality disorder, 3 – those with chronic brain damage, 4 – those who will miss more than three sessions due to health reasons, 5 – those with any medical conditions which would prevent them from participating in the course. The recipient was asked to tick the appropriate box and return the form. The three possible boxes that could be ticked were Medically Fit, Physically Unfit or Mentally Unfit.

166. It is manifest that prisoners with acute psychotic illnesses or chronic brain damage are unsuitable candidates for SOTP. However, prisoners not suffering from such serious disorders might also be unsuitable candidates for a course as intensive as SOTP.

167. A related form is entitled Healthcheck – Information required and states that the Medical File should be checked for the following:

(i) mental health issues either in community or while in prison;

(ii) heart conditions;

(iii) serious known medical conditions;

(iv) requires regular visits to outside hospital;

(v) requires regular visits to healthcare;

(vi) pending surgery;

(vii) any medication currently taking.

A handwritten note at the bottom of the man's form states: *"collapsed in workshop – March 05. No further problems reported."*

168. My investigator was told by the psychology assistant that she made this note herself. She had been told that Healthcare staff were too busy to respond to the form she had sent them. She was invited to attend the Healthcare Centre in order to study the clinical records of the men identified on the form. She made no note of the man's bowel disorder or learning disabilities. Nor did she mention the misgivings in relation to SOTP expressed by the psychiatrist in her psychiatric report to the Crown Court written in June 2003.

169. The psychology assistant was placed in an intolerable situation and I emphasise that I make no criticism whatsoever of her actions. She was inexperienced and could not possibly have been expected to have the expertise to extract the necessary information from the records.

170. I am not convinced that the forms my investigator examined ask all the right questions. I was also dismayed to discover that the form was not sent to the Healthcare Centre until 6 September. That was just over a week before the man's death, and at a time when he and the other named prisoners on the form had already completed two and a half months of ASOTP. The psychology assistant assumed that a similar form had been sent to the Healthcare Centre previously, but there is no evidence that this happened.

171. The psychologist also suggests that the SOTP audit criteria could be reviewed to give more encouragement and weight to assessment and support. She suggests that WAIS assessments need to be fully interpreted, with the interpretation and conclusions of this assessment being communicated clearly to the group facilitators. (WAIS stands for Wechsler Adult Intelligence Scale and is a tool used by psychologists to assess intelligence.) She also refers to the support needs of all ASOTP candidates, and the possibility of drawing up a care plan for ASOTP group members that involves programme and residential staff.

172. My investigator has studied the most recent Accredited Programmes Audit Document issued by OBPU in May 2005. In the section of the document headed Treatment Management and Integrity, there is an audit requirement that "Prisoners are selected for an intervention through assessments of need, risk and suitability." The action required by the Audit Document is that, for ASOTP candidates, a full WAIS should be administered and fully interpreted for each group member prior to the start of the programme. I agree with the psychologist that it is vital for the conclusions of this assessment to be communicated clearly to the group facilitators.

I recommend that OBPU reviews the Audit Document and ASOTP Treatment Manual with a view to ensuring that the interpretation and conclusions of WAIS assessments are communicated clearly to group facilitators.

173. The psychologist's letter refers to the support needs of all ASOTP candidates. In her conclusion she refers to the need for *"a greater focus on monitoring out of group support".*

174. ASOTP is an arduous and very demanding programme for both the facilitators and the prisoners who undergo it. At the time of his death, the man was at block 7 of the programme and I note that that block is described in the Treatment Manual as *''extremely stressful and demanding"*.

175. I was not able to see any references to support for prisoners in the OBPU Audit Document. The "Old Me" block of the Treatment Manual includes two paragraphs in a section entitled Other People Who Can Help Me. In that section, the facilitators are advised to tell the group that it is important to think about other people in their lives who can

help them. A list of possible helpers is set out, but all the people on the list, such as Probation Officers, key family members, GP and neighbour, are outside the prison. There is no discussion in this section of the possibility that the prisoner will need help in the here and now – and not just in the future when he is trying to apply the learning from ASOTP treatment in the outside community.

176. The question of support for the man also came up in a supervision session between the facilitators and Treatment Manager, on 15 July. A requirement of the programme is that a Record of Supervision is kept. The Audit Document explains that supervision has a number of purposes - including the development of the tutors' skills by providing feedback from observations made by the Training Manager, and allowing the tutors to raise questions or bring sections of videotape along for review. (All sessions on ASOTP are video taped.)

177. The meeting on 15 July was attended by the treatment manager and all three tutors on the man's course. They talked about planning for the forthcoming block 7. The facilitators were recorded as saying that they were concerned the man might find the walk and talks difficult: *"The man may therefore need some further support out of the sessions."*

178. In interview, one of the facilitators explained that he saw the necessary support as coming from the tutors themselves at times when the group was not meeting. I do not think it is fair or sensible for the tutors to carry this heavy burden alone. The psychologist suggests that the care plan for ASOTP group members should involve both programme and residential staff, although there are complex cultural issues which cannot be addressed simply by writing a policy document.

I recommend that the Treatment Manual includes a section on sources of support, not confined to the tutors, which can be accessed inside the prison by prisoners doing ASOTP.

179. There is evidence that, on at least one occasion, the man wanted to leave the programme. In interview, one of the facilitators remembered a time when the man felt that confidentiality had been breached on the course. Somebody who was not on the course had been talking about his offences on the landings. The facilitator could remember talking to the man about the problem. At the end of their conversation, the man said that he would stay on the course. The facilitator added that the man might even have put it in writing because he *"was a great one for sending us notes on various things"*.

180. My investigators were given a note addressed To Whom it May Concern in the man's distinctive handwriting. The spelling mistakes in the original have been corrected in the following extract:

"I, is currently doing SOTP AP5. I am wishing to come off the course for a while as I fear for my safety and cannot sleep at night as people who is not on my course are wishing to know why I am on the course and are asking people who are on my course about my offences."

181. In the same note, the man writes about self-harming in the past and being *"bollocked"* by his best mates for hurting himself. The note also refers to the man being *"on his own"* shortly when his best mate, was due to be released from Wymott. The man's mate was indeed released from Wymott to a hostel in a nearby city exactly a week after the man's death.

182. The facilitator disclosed during his interview that the information about the man's medical condition contained at the beginning of his Progress in Treatment Log may not have been included at the beginning of the course. He said that the information would have been typed in when it became available. He had not typed the entry himself, "*so I couldn't say that it was actually written at the beginning of the course. It could have been written in at any stage when we found that out."*

183. At the end of his interview, the facilitator considered that the pressures of SOTP might have been a contributory factor to what happened on the afternoon of 14 September in the man's cell. But the officer added that he could not believe that SOTP was the sole cause. He referred to the man's debt problem and suspected there was a lot of banter on the man's landing that afternoon, *"probably taking the mick out of him because he was cleaning his cell, possibly they had spotted his new laundry bags coming in."* The facilitator named a particular prisoner with an extremely low IQ who might have mocked the man.

184. The facilitator thought it was, *"just a series of a number of things that had come together on that afternoon that just tipped him over the edge, and if somebody had only had the slightest idea and gone in and talked to him that afternoon, I suspect by the evening he would have been over the worst of it and able to cope again."*

185. A final SOTP issue worthy of note is that the Treatment Manager received less information about the difficulties the man was experiencing than the facilitator thought she did. My investigator asked the facilitator if information about scratches the man had made to his wrists was made available to the treatment manager. He replied that he was pretty sure that she knew about them, and then added that she would definitely have been informed. He was asked by whom and replied, *"I would have thought by one of the facilitators."*

186. In her interview, the treatment manager said that she could not recall the facilitators discussing with her the man's desire to come off the course before his death. Shortly afterwards, she was asked if one of the facilitators had told her about the scratches on the man's arms.

She said that she had not been aware of the scratches before his death. At the end of her interview, she spoke of the importance of facilitators using supervision effectively. She explained that she is "*reliant on the facilitators approaching me with any issues and problems and that means them coming prepared to supervision with issues."*

187. Although the facilitator was *''pretty sure"* that the treatment manager had been informed of the scratches on the man's arms, I think it is likely that she had not been so informed. I cannot be certain about this matter because it was not possible to interview the facilitator who was on maternity leave. However, I emphasise the importance of supervision sessions considering all information that suggests an individual prisoner is in distress.

FINDINGS AND CONCLUSIONS

188. No note was found in the man's cell after his death, but it is highly probable that he took his own life. I have considered the claim made by another prisoner in interview that the man would not have known how to tie the ligature found around his neck. My investigator discussed this question with the detective who led the police investigation. I understand there are a number of factors that strongly suggest to the police that the man was not attacked by another prisoner or prisoners. He was described by the detective as a stocky man and he was facing the cell door when he was discovered. The police supposition is that the man would have struggled violently if another prisoner or prisoners had attempted to harm him against his will. As he was facing the cell door he would have been in a position to see, and resist, any person who entered his cell with evil intent. There were no signs of scrapes or scratches on his body and his next door neighbour would surely have intervened if he had heard anything amiss.

189. The man had committed a number of grave sexual offences, but he was himself a very vulnerable young man who had previously received significant levels of support, both in the community and at Lancaster Farms. In terms of prisoner support, the man's situation on B3 landing was probably the best it had been during his time at Wymott. I single out for particular praise the contribution to the man's welfare made by the older prisoner. I think that the older prisoner had the man's best interests at heart and that he gave the man quiet, unspectacular assistance in areas that really mattered. He taught the man to put his shoes on the correct feet, helped him to tidy his cell and made unofficial arrangements for the man to have clean clothing when he had soiled himself. He acted as a trustworthy confidant and counsellor late in the evening when staff had gone home.

I recommend that the older prisoner receives a formal letter of thanks from the Governor or Area Manager.

190. I conclude that the man received a high level of care and individual attention during the time he spent at Lancaster Farms. There he was located for many weeks in the Healthcare Centre, where weekly reviews and personal care plans were drawn up. There was even a straightforward list of things that the man had to do each day (the man's Daily Checklist).

I recommend that a copy of this report is sent to the Governor of Lancaster Farms drawing attention to my comments on the care the establishment offered to the man.

191. Although the man received excellent healthcare support while he was at Lancaster Farms there is no evidence that his continuing healthcare needs were adequately conveyed to Wymott. The Prison Service's performance Standard on Health Services for Prisoners (Number 22) states at 22.2 that each prison must have written and observed guidelines in place which set out the procedures for transfer, ''ensuring information on continuing care is conveyed to other establishments on transfer.''

192. During the course of my investigation, on 10 February 2006, the Prison Service issued Prison Service Order (PSO) 3050 on Continuity of Healthcare for Prisoners. Chapter 5 of the new PSO deals with the transfer of prisoners. Three paragraphs in the chapter are devoted to the topic of continuity of care between establishments, with paragraph 12 being especially relevant:

''Patients with more complex health needs may require more detailed planning such as communicating directly with the receiving health care team in advance of transfer.''

The last part of Chapter 5 deals with receiving transfers and ends with the instruction:

''Each establishment must develop a local protocol and procedure for the reception of transfers to its establishment that meets its local needs and is responsive to any significant clinical events.''

I recommend that the Governor of Lancaster Farms reviews the arrangements for ensuring continuing healthcare for young men transferring to other establishments I recommend that a local protocol is drawn up urgently at Wymott for the reception of transfers, especially those with significant health issues.

193. In his sentencing remarks on 12 September 2003, the Judge said that he had had particular regard to the three psychiatric reports. He said that those reports referred to the difficulties which the man might well experience while serving his sentence and the Judge knew *"from what I have been told that those difficulties have to a certain extent already manifested themselves".* The Judge indicated that all the reports on the man should accompany him to where he serves his sentence, *"which I hope will be of some assistance".* There is no evidence that the sentencing judge's remarks followed the man around the prison system. There was no copy of them in his prison record and they were only obtained during the course of my investigation. There is scant evidence that information about the man's vulnerability contained in the reports was widely known or used to inform his treatment at Wymott. In response to my draft report colleagues in SCG have informed me that a review of the Prisoner Escort Record (PER) is currently being undertaken. PER is the document used to record information of special importance as prisoners are transferred from one criminal justice agency to another

and within the prison system. Another relevant initiative is the Improvement and Implementation Project which is presently scrutinising the work of the Prison Escort and Custody Service.

194. There is compelling evidence that the man was struck and called names by other prisoners. One of the facilitators thought that the man had suffered from bullies right through his sentence because of the way he was, *"because physically he wasn't the most able of people. He looked a little bit strange and, yes, he had been bullied, he had come to us and said he had been bullied and we dealt with it."* Prisoners told my investigators that the man was subjected to name calling, tormented by some prisoners and told that he was smelly by others. Such assaults on his dignity cannot have assisted his psychological wellbeing.

195. I commend the Officer B highly for the energy, compassion, determination and initiative he showed on the last afternoon of the man's life. The man told him openly about his bowel problem and Officer B immediately set about trying to provide assistance. I congratulate Officer B for what he did, but also express sadness that it was left to a conscientious prison officer on the last afternoon of the man's life to come up with a decent solution to such a basic human need. Officer B kept the man away from work on the afternoon of 14 September so that he could attend to the issues that had been brought to his notice. (I think this was the right thing to do, although keeping a prisoner away from work is a decision that should probably have been agreed with the Senior Officer on the wing.)

The Governor should send a letter of commendation to Officer B.

196. There are constant references in the man's prison record to the untidiness of his cell. Just a month before his death, the wing handover book contains a note as follows:

"The man warned re the state of his cell. It has been cleaned up and looks OK but why does it still smell."

197. Two immensely experienced officers did not know about the man's bowel problem before the last day of his life, although they worked regularly on his landing. Staff on the wing were actively hindered from giving the man appropriate care because they were not aware of his bowel problem.

I recommend that the Governor and Primary Care Trust work together to set up a system which will supply "need to know" medical information to carefully identified non-clinical staff.

198. The young man who died badly needed a staff champion. Yet no Personal Officer interview was held with him for the five month period between the end of March and the end of August 2005. If Wymott is to retain a Personal Officer system, then such gaps are highly

undesirable – even a very brief contact and entry in the wing file is better than no entry at all. I think it is likely that Wymott's anti-bullying and violence reduction procedures would have operated more successfully in the man's case if there had been more regular contact with a Personal Officer. Such contact would have given the man further opportunities to raise any concerns that he had and given the officer the chance to ask direct questions about the welfare of a clearly vulnerable young man.

I recommend that the Governor considers whether there are ways to make the Personal Officer scheme at Wymott work more effectively.

199. I am extremely grateful to the psychologist who is the National Head of the Sex Offender Treatment Programme, for the detailed response she supplied in mid October to seven questions put to her. She herself recognised that there were a number of areas where delivery of SOTP might need to be adjusted *"to reduce the likelihood of any repetition of this kind of tragic outcome".* She highlighted the need to review communications between Healthcare and Psychology Departments regarding a prisoner's suitability for sex offender treatment. I have no doubt that the medical clearance arrangements in place at the time of the man's death need to be reviewed and improved. I believe that pre-assessment scrutiny before a prisoner is selected for a SOTP needs to be more rigorous. In particular, better systems must be devised for supplying relevant medical information to Programmes staff.

I recommend that OBPU and Prison Health jointly examine communications between Healthcare and Psychology Departments regarding a prisoner's suitability for sex offender treatment. Particular attention should be paid to medical clearance arrangements and to the provision of relevant medical information to Programmes staff.

200. The psychologist criticises the medical clearance form sent by the Wymott's Psychology Department on 6 September for listing only narrow programme exclusion criteria and not allowing for other issues to be communicated. The form was sent to the Healthcare Centre when ASOTP5 was already far advanced. ASOTP is making a critically important attempt to change the behaviour of sex offenders for the better. The Treatment Manual announces that *"one of the main goals of the ASOTP is the identification and restructuring of pro-offending beliefs into anti-offending beliefs".* In common parlance, this means helping sex offenders to face up to making the change from old me to new me. The process is lengthy and difficult but potentially life changing. It is asking prisoners to talk about and to renounce what the facilitator called probably the worst things they have done in their lives. It is not acceptable to seek appropriate medical clearance when participants have already been on the group for many weeks.

I recommend that no prisoner at Wymott should begin SOTP or ASOTP unless the necessary medical clearance has been obtained. This recommendation may need to be repeated nationally.

201. My investigators have discovered that the psychology assistant had to write her own response to the questions posed in the form she sent to the Healthcare Centre on 6 September. That situation should never have arisen and must not be repeated. Information about clinical factors which may prevent a man's participation in SOTP must be supplied in timely fashion by suitably competent people. I am very encouraged to learn of the pre-assessment arrangements now being developed at Wymott. These mean that senior professionals from the Healthcare Centre and Psychology Department will sit down together to assess possible candidates for courses so that informed decisions on suitability are taken.

202. Neither the facilitators nor the Treatment Manager had seen the psychiatric report, so they were not aware of her opinion that the man would be unable to cope with regular SOTP groups in prison. There is also evidence that staff at Wymott may not have seen relevant information that *was* available before offending behaviour programmes began. The psychologist wrote in good faith, at paragraph 1.2 of her letter, of evidence that at least some information about the man's medical and mental health was available to the facilitators before ASOTP began. She referred to the description of FACS at the beginning of the Progress Log. However, information that came to light after she wrote her letter suggests that the facilitators may have had less information than she thought they had. One of the facilitators explained in interview that information at the beginning of the Progress Log could have been written in at any stage when it actually became available. He added that, in some cases, the facilitators have all the information they need on group members before the course has started. But in other cases, *"I have known to almost complete a course when things like depositions, court depositions have arrived."* He said it was very important to have that kind of information *"because then you know who you are dealing with".*

203. It was only after the man had completed his ETS programme in February 2005 that programmes staff became aware that he experienced a number of learning and developmental difficulties. These difficulties may well have explained, or partly explained, why the man did not respond to parts of that course. There is no evidence that the proposed multi-disciplinary case conference to address the man's outstanding needs whilst in prison, as suggested in the post-ETS review, ever took place. There is no evidence that SOTP staff were aware of such a recommendation. It is not possible to find out exactly what information the facilitators did see before SOTP began:

I recommend that clear guidance is published for Programmes staff and facilitators about the kinds of information they should attempt to obtain before working with a prisoner in an offending behaviour group.

I recommend that OBPU should consider issuing national guidance on how staff are to obtain relevant prisoner information before delivering accredited programmes.

204. The existing national Treatment Manual for ASOTP was issued in September 2003. I suggest that it may be necessary to issue amendments to the existing manual or to produce a revised version of it. Page 41 of the manual refers to each group member having approximately three sessions in the *"hot seat".* This expression was widely used at Wymott, but OBPU may wish to reflect on whether such a term should continue to appear in the manual. The psychologist also addressed in her letter the issue of out-of-group support. The manual itself recognises that Block 7 is extremely stressful and demanding and that most of the group members will find it very difficult. It would be helpful for national SOTP managers to reflect on questions such as who should give support to SOTP group members and when it should be offered.

I recommend that the guidance on support in the Treatment Manual (and other relevant documents such as the SOTP Audit Criteria) should be urgently reviewed.

205. Although the OBPU Audit document states that all sessions on ASOTP must be videoed, at the time of writing some videos of individual sessions could not be found.

I recommend that a robust system is introduced without delay at Wymott for storing videos of ASOTP sessions.

206. In the penultimate paragraph of her letter, the psychologist makes a number of technical criticisms in relation to course delivery. She highlights the importance of wind-down time at the end of a session, the need to debrief and praise group members who have undertaken difficult work during the session, and the importance of communicating in a manner that will be easily understood by men with intellectual difficulties. I draw these matters to the attention of the Governor.

207. When the man was discovered hanging, Officer B went to find what he called in interview a self-harm kit in the office. He could not find one. The first staff to arrive in the man's cell had great difficulty in untying the double knot in the ligature. Staff suggested to my investigators that they should be issued with ligature knives and that more offices on the wing should hold emergency response kits. I do not write of the Officer B's difficulty in order to embarrass him, but to

emphasise the training point that front-line staff must be regularly briefed on the location (and, ideally, use) of emergency equipment.

I recommend that anti-ligature knives be issued to all prison officers at Wymott who have direct contact with prisoners.

208. When staff succeeded in removing the ligature from the man's neck, he was placed on the bed in his cell. The recommended action in Prison Service Order 2700 on Suicide and Self-Harm Prevention is that once a prisoner has been cut down, he should be placed on his back on a flat, solid surface. I do not believe that the man's death would have been prevented if he had been placed on the cell floor, but in a report on a prisoner's death from natural causes at Wymott on 8 June 2005 I also noted that CPR should ideally be carried out on a hard surface, and highlighted the risks of staff not being properly first aid trained.

I recommend that the Governor reminds all staff of the PSO requirement to place a prisoner on his back on a flat, solid surface if he is found hanging.

RECOMMENDATIONS

1. I recommend that the Governor reviews what happened after the man's next of kin application of 3 May with a view to devising a system for making emergency contact with relatives that is efficient, reliable and as un-bureaucratic as possible.

2. I recommend that OBPU reviews the Audit Document and ASOTP Treatment Manual with a view to ensuring that the interpretation and conclusions of WAIS assessments are communicated clearly to group facilitators.

3. I recommend that the ASOTP Treatment Manual includes a section on sources of support, not confined to the tutors, which can be accessed inside the prison by prisoners doing ASOTP.

4. I recommend that the older prisoner receives a formal letter of thanks from the Governor or Area Manager.

5. I recommend that a copy of this report is sent to the Governor of Lancaster Farms drawing attention to my comments on the care the establishment offered to the man.

6. I recommend that the Governor of Lancaster Farms reviews the arrangements for ensuring continuing healthcare for young men transferring to other establishments. I recommend that a local protocol is drawn up urgently at Wymott for the reception of transfers, especially those with significant health issues.

7. The Governor should send a letter of commendation to Officer B.

8. I recommend that the Governor and Primary Care Trust work together to set up a system which will supply "need to know" medical information to carefully identified non-clinical staff.

9. I recommend that the Governor considers whether there are ways to make the Personal Officer scheme at Wymott work more effectively

10. I recommend that OBPU and Prison Health jointly examine communications between Healthcare and Psychology Departments regarding a prisoner's suitability for sex offender treatment. Particular attention should be paid to medical clearance arrangements and to the provision of relevant medical information to Programmes staff.

11. I recommend that no prisoner at Wymott should begin SOTP or ASOTP unless the necessary medical clearance has been

obtained. This recommendation may need to be repeated nationally.

12. I recommend that clear guidance is published for Programmes staff and facilitators about the kinds of information they should attempt to obtain before working with a prisoner in an offending behaviour group.

13. I recommend that OBPU should consider issuing national guidance on how staff are to obtain relevant prisoner information before delivering accredited programmes.

14. I recommend that the guidance on support for prisoners undergoing ASOTP in the Treatment Manual (and other relevant documents such as the SOTP Audit Criteria) should be urgently reviewed.

15. I recommend that a robust system is introduced without delay at Wymott for storing videos of ASOTP sessions.

16. I recommend to the Governor that the action plans and recommendations drawn up at reviews following offending behaviour programmes should clearly indicate who is accountable for implementing them.

17. I recommend that anti-ligature knives be issued to all prison officers at Wymott who have direct contact with prisoners.

18. I recommend that the Governor reminds all staff of the PSO 2700 requirement to place a prisoner on his back on a flat, solid surface if he is found hanging.

19. I endorse all the recommendations made by the clinical reviewer at the conclusion of his Clinical Review. These recommendations are:

    - It is recommended that a senior nurse be responsible for the review of care plans and that minimum standards for the completion of care plans be implemented and reviewed on a regular basis.

    - It is recommended that all entries to the Inmate Medical Record be signed, the signature printed underneath and clearly dated.

    - The Inmate Medical Record to include all relevant Prescription and Administration Record Charts and a record made if a drug is not administered.

    - It is also recommended that all prison pre-printed clinical documentation includes space for the establishment to identify itself on the form.

- The quality of records should be subject to regular review and audit in line with current best practice and professional standards.

- A comprehensive mental health risk assessment of all vulnerable prisoners should be implemented at HMP Wymott.

- A policy for the pro-active follow up of vulnerable at risk prisoners should also be developed.

- It is recommended that a review of confidentiality within Prison Healthcare be undertaken with a particular and initial emphasis on those prisons providing SOTP.