Investigation into the death of a man at HMP Manchester in October 2006

Report by the Prisons and Probation Ombudsman for England and Wales

February 2008

This is the report of an investigation into the death of man at HMP Manchester in October 2006. The man was discovered by another prisoner suspended from the window bars of his cell. Despite efforts to resuscitate him, he was pronounced dead in his cell. The man was 36 years old.

I would like to extend my sincere condolences to the man's family and to all those touched by his untimely death. I hope my report provides answers to the concerns they may have. Although he was called by his first name whilst in prison, he was known by his middle name to his family and friends. I have referred to him by his middle name throughout this report in recognition of that fact.

The investigation has been undertaken on my behalf by one of my colleagues. She was assisted by another of my investigators. I would like to thank the Governor of HMP Manchester and his staff for their co-operation during this investigation. Thanks are also due to the Cluster Director and Acting Head of Nursing, South Locality, Manchester NHS Primary Care Trust, for conducting a clinical review of the healthcare the man received whilst at Manchester. I must apologise both to the prison and to the man's family for the delay in producing this report.

My report makes eight recommendations. Four of them reflect my concerns about the healthcare management of the man's symptoms of depression and the failure to ensure that a mental health assessment was carried out. Two of the others centre on ensuring that a bereaved family's wishes are heard and acted upon.

HMP Manchester is formally recognised as a high performing prison. I am certain that the Governor and management team will wish to take forward the lessons emerging from this investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman **February 2008**

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SUMMARY

1. The man was arrested on 3 August 2006 on suspicion of murdering his best friend who was also his business partner. The next day he was examined by a police doctor who assessed his risk of self harm as standard. The man told the doctor that he had harmed himself in the past when frustrated and upset. The doctor noted his comments on a Detained Person's Medical Form. After appearing at magistrates' court on 7 August, he was remanded in custody and taken to HMP Forest Bank.

2. On reception, the man was asked questions by a healthcare assistant (HCA) as part of the normal procedure. He responded that he had not tried to harm himself before and did not feel suicidal. The day after the man's arrival, he saw a doctor who conducted a physical check of his health. The words "mental health review" were written at the bottom of the doctor's notes. Such reviews are routinely carried out where a prisoner has been charged with murder. In the man's case, however, there is no evidence that the review took place.

3. The man was taken to HMP Manchester after his next court appearance. A copy of the police's Detained Person's Medical Form was placed in his security file but not in his clinical record. He was seen by a General Practitioner on15 August who wrote in his clinical record that his poor English made it difficult to obtain a medical history. He added that the man was depressed, feeling low, found it difficult to get on with people and was not sleeping. The GP prescribed an anti-depressant. It is not clear whether the man took any of the medication prescribed and, after he did not turn up for a scheduled doctor's appointment, he was not rebooked. HMP Manchester did not explore the reasons why he had not appeared.

4. The man underwent a four-week induction period on G wing as a new prisoner to Manchester but could not understand parts of it due to language barriers. His language and educational needs were not assessed.

5. The man moved to K wing and shared a cell with a prisoner who was also observing Ramadan. His cellmate observed that he felt ashamed about having killed his friend. To him, the man appeared depressed and spent most of his time sleeping in bed and not socialising much with other prisoners. His cellmate asked other Muslim prisoners to talk to him but they achieved only limited success. Occasionally the man would chat about his family but at other times he would not respond to conversation. His cellmate told my investigators he did not raise concerns with K wing staff about the man's behaviour as he did not find them caring and felt they did not like Asian prisoners.

6. On 9 October 2006, staff were alerted to a crisis in the man's cell after a friend looked through the observation panel of his cell door and saw

him suspended from his window by a ligature. Despite efforts to resuscitate him, the man was pronounced dead in his cell.

7. After learning of the man's death, his family asked HMP Manchester for an opportunity to meet his cellmate and the prisoner who found him. The meetings did not materialise and, after waiting five months after his death, the man's aunt was asked to put her request in writing. The man's family felt they had been sidelined. They have found it particularly difficult to accept the manner of the man's death during Ramadan.

8. I make several recommendations concerning the management of the man's healthcare and the importance of acknowledging the wishes of a bereaved family.

INVESTIGATION PROCESS

9. My investigators visited HMP Manchester on three occasions and were given access to all prison records relating to the man who died. These included his main prison record, his medical records and statements from staff. They also obtained CCTV footage of K wing from Greater Manchester Police. Notices were issued to staff and to prisoners for display in the prison, informing them of the investigation and inviting them to contact my investigators with relevant information.

10. My investigators interviewed staff and prisoners and met representatives of the Independent Monitoring Board and Prison Officers' Association to offer them the opportunity to raise relevant issues. Contact was made with an appointed Sergeant of Greater Manchester Police who confirmed that there was no third party involvement in the man's death.

11. The man's family was offered, and accepted, the opportunity to contribute towards the investigation process. One of my Family Liaison Officers, and one of my investigators visited the man's aunt (and mother-in-law) to discuss the issues the family wished to raise. These included concerns about the lack of information on how the man had been discovered and the aftermath, the way they had been told about the man's death, and the difficulties they had experienced in arranging to meet prisoners who knew him.

12. A clinical review was conducted by the Cluster Director and Acting Head of Nursing, South Locality, Manchester NHS Primary Care Trust.

13. After seeing a draft version of this report, I am pleased to note that the Prison Service have accepted all of my recommendations.

HMP FOREST BANK AND HMP MANCHESTER

14. HMP Forest Bank is a privately managed prison run by Kalyx (formerly known as UK Detention Services). It is a local prison serving the courts of the North-West. Opened in 2000, Forest Bank currently has capacity for 1,064 male prisoners.

15. HMP Manchester is a refurbished, partially rebuilt Victorian prison just outside the city centre. It serves the local courts of the Greater Manchester area and also holds high security prisoners from all over England and Wales. K wing has capacity for 230 prisoners in double cells.

16. Manchester was last inspected by Her Majesty's Inspectorate of Prisons (HMCIP) in 2004. The inspection report found that the prison had a comprehensive, up-to-date and well publicised suicide and self harm policy, supported by a proactive committee. It found that staff were less reticent in mingling with prisoners than on the previous inspection in 2001. However, although commendably high levels of time out of cell and regular association were offered, the prison needed to deliver more positive staff-prisoner interaction.

17. Manchester NHS Primary Care Trust is responsible for commissioning healthcare. Commenting on the delivery of primary healthcare, the HMCIP report said that there were no formal triage protocols and healthcare staff did not follow up prisoners who failed to keep a GP appointment.

KEY EVENTS

18. On 2 August 2006, the man had an argument with his friend and business partner, who he believed was cheating him financially. This culminated in the man allegedly stabbing his friend several times and strangling him with a bed sheet in a fit of anger. The man was arrested by police late in the evening on 3 August.

19. In the early hours of 4 August, the man was interviewed by a police doctor who wrote on a Detained Person's Medical Form that the man spoke poor English but understood the reason for his arrest. He assessed the man's risk of self harm on a three point scale ranging from High to Standard as "standard". Later that day, the man was seen by another police doctor. Completing a Detained Person's Medical Form, the doctor noted that the man told him he felt "mentally tired and had been suffering for a few weeks." He had recently suffered alcohol-related problems but had not taken alcohol for the previous three days. The doctor wrote that the man was being treated by his General Practitioner for insomnia and, although he had not had formal psychiatric treatment, had harmed himself in the past and said he injured himself when frustrated and upset. The doctor assessed the man's risk of self harm as "medium" and advised regular observation. The man was given 10 grams of Chlordiazepoxide, which can be used in the treatment of alcohol-addiction or as a short-term anti-anxiety medication. On 6 August, he was charged with his best friend's murder.

20. On 7 August, the man was remanded in custody and taken to HMP Forest Bank. On reception, he was seen by a healthcare assistant (HCA) for a First Reception health screen, a standard health check procedure when a new prisoner arrives in prison. The man told him that he had seen a doctor and had been prescribed sleeping tablets. He had sustained lacerations to two fingers but these had been cleaned and dressed in hospital prior to his arrival at Forest Bank. He was asked if he had ever tried to harm himself, and whether he felt like harming himself then; he replied "No" to both questions. The man did not have concerns about his physical health apart from his fingers. His Reception/Induction checklist was completed by the reception officer. It recorded reading, writing and understanding English as areas of concern.

21. On 8 August, the man saw the prison doctor who conducted a physical check of his health. The words "mental health review" are written at the bottom of the doctor's notes of his consultation with the man. However, as the clinical review points out, "it is unclear as to whether this is a request or a note in the record, and there is no evidence that the referral to Mental Health services was made."

22. The man was seen by a doctor on 10 August who prescribed medication for an infected wound to his fingers and wrote in his

medical record, “Depression – murder case, sleeplessness, frustrated. Amitryptyline.”

23. On 11 August after appearing at court, the man was returned to custody but was taken to HMP Manchester. A nurse wrote in his medical record that he had been spoken to and had no medical problems at that time. A Modified First Reception Health Screen form was placed in his medical record but was not completed. As a new prisoner to Manchester, the man was assigned to G wing for induction so that the procedures of the prison could be explained to him and his needs assessed. He was allowed to make a telephone call to his brother-in-law to let him know where he was. His First Night Induction form stated that it was his first time in custody, that he had some difficulty conversing in English and he could not read or write.

24. In the man’s Record of Events, a prison document where staff can record relevant information or observations about a prisoner, the prison officer noted on 13 August that although the man did not speak English he seemed in good spirits and was getting help from his cellmate.

25. On 15 August, the man was seen by a GP who in an unsigned entry noted the knife cuts to his fingers and wrote “Depressed (poor English, difficult to [illegible] make history). Feeling low [illegible]. Difficult to get on with other people not sleeping. He claims was on “AD’s” before (Amitriptyline?) Start Zispin 15mg prn. Review in 2-3 weeks.” A prescription valid for 28 days for Mirtazapine (the generic name for Zispin, an anti-depressant) was written up for seven days supply at 15mg daily. However, there is no indication whether the man actually took any of the medication prescribed.

26. The foreign nationals officer noted on 19 August that, “although the man claims not to speak any English, I have had 2 conversations with him and if helped, he is more than capable of understanding.”

27. The officer wrote the next day that the man had been moved to a cell with another speaker of his mother tongue, but wanted to change cells again as he was complaining that he could not sleep because of a headache. The officer commented, “once again he complained of not being able to understand but is more than able to put a case for moving cell in excellent English.” The wing officer made an entry in his Record of Events on 2 September to say that, although the man spoke a little English, she had been able to speak to him. The foreign nationals officer wrote the next day that the man spoke little English but had been receiving support from other Asian prisoners and had no immediate concerns.

28. On 14 September, the man’s induction period as a prisoner new to Manchester was completed. As part of his Custody Plan (designed to identify areas of need to be addressed whilst in prison such as housing need, debt counselling, drug use), The man had a final interview with

the induction officer to assess the effectiveness of the induction period. The officer completed a close-off interview form on which he wrote that, although the man had completed the full programme, he did not feel it was useful because he did not understand parts of it due to language barriers. No outstanding issues were recorded but the officer observed that the man needed to attend education classes. Although the Custody Plan contained a section for education needs to be assessed by education staff, this was not completed. Having finished the induction period on G wing, the man was moved to K wing for unconvicted prisoners.

29. On 18 September, the last entry in the man's medical record whilst he was alive noted that the man "failed to attend MO call-up – not rebooked". This meant that although he had been scheduled to see a doctor, he did not turn up for the appointment and was not given another.

30. According to the man's Record of Events, on 19 September his conduct was assessed according to behaviour, cleanliness, attitude, punctuality and workplace comments. The man was given three out of a possible five for all categories except attitude which was two out of five. The officer's signature is not legible. On 5 October, a similar exercise was conducted where he was given three out of five for all categories except workplace comments which was left blank. Again, the officer's signature is illegible. Apart from a management check signature on 7 October, the Record of Events does not give any further information about the man or his activities.

31. On K wing, the man shared a cell with prisoner A. At interview with my investigators, he said that both he and the man had been at Forest Bank at the same time. Prisoner A was sent to Forest Bank after a court appearance but both he and the man ended up back in Manchester eventually. An officer had placed them in the same cell on K wing because they were both Muslims observing Ramadan. As this necessitated waking up early to eat and pray, it made sense for them to be together and he was happy to share a cell with him.

32. Asked how he found life with the man, prisoner A said he shared his tea and coffee-making supplies with the man. If the man wanted any, he could help himself. The man spoke to him about the reasons why he ended up in prison. The man felt shame at having murdered his friend and did not regard himself as a good person because of this. Asked by my investigators to describe the man's mood, prisoner A replied:

33. "All the time he was depressed, not happy, not better, all the time he was sleeping in the bed, not talking to anyone, not any other prisoners … not going for exercise and not any association."

34. Prisoner A said that in the mornings he would get up and go to work in a prison workshop making sheets and towels. The man would remain in bed as he did not have a job. When prisoner A returned from work, the man would still be in bed. In the evening the man would leave his cell for a shower, return and then go to sleep on the top bunk. He would turn off the cell light and would not talk to anyone or watch television.

35. Prisoner A said he was concerned about the man's mental state so he asked two or three other Muslim prisoners to talk to him but the man would not respond to them. He said that he tried to engage the man in conversation but there were times when he would not even speak to him. On other occasions, the man would show him photographs of his wife and sons that he received through the post and talk about the times they had visited him in Manchester.

36. My investigators asked prisoner A whether he had talked to any K wing staff about his concerns for the man. He replied that he had not done so because he did not get on well with them or find them caring. He cited an example of being told he would get a warning after asking an officer several times for a doctor because he had a pain in his head. He described all the staff as being like that rather than just one or two. He felt that Asian prisoners were not liked by officers on K wing and that other Asian prisoners on K4 landing felt the same way. Asked if there were other members of staff in the prison who could address the situation, he did not think so. He said there had been occasions during Ramadan when, although prisoners had made applications to attend Friday prayers, the bulk of them had been kept waiting on the wing whilst only a few had been taken over to pray.

37. Prisoner B, a friend of the man in Manchester, told my investigators that about five or six Pakistani prisoners including the man used to talk together. He also did not tell staff how the man was feeling though, because his English was patchy and he said staff were not responsive.

38. Prisoner A said that on the morning of 9 October an officer had banged on his cell door for him to get up to go to court. The man was awake and told him that the officer had called him. He got ready, and told the man to keep the tea, coffee and sugar as he was leaving and said goodbye. The man replied, "you are lucky you are going on but my life is here."

39. Prisoners observing Ramadan fasted during the day so they were not unlocked at lunchtime for a meal. Once it was time for the daily fast to end, they collected their evening meals and pre-prepared food in an insulated box to eat during the hours of darkness. Those who had jobs or education classes during the day attended them in the normal way. Although the cells of those who did not have a job were left unlocked during association time, some slept during the day to compensate for having been awake early.

40. On 9 October, the routines that K wing usually followed in the morning were changed to allow staff to attend the funeral of a colleague. This meant that prisoners were unlocked at 7.30am to collect hot water and hand in their empty food boxes. They returned to their cells until lunchtime and were served a cold packed lunch at their cell doors instead of a hot meal collected from the servery.

41. Landing officer 1 unlocked the man in the morning on 9 October. Landing officer 2 saw him at lunchtime through the observation panel of his cell door when he was checking that all prisoners were accounted for on his landing. He said the man was lying on his side in bed. Closed Circuit Television (CCTV) footage of K4 landing obtained from Greater Manchester Police shows that this check took place at 11.55am. Landing officer 2 told my investigators that he had worked on K wing for two years but, although he was based on K4 landing, he could not readily recall what the man looked like.

42. At approximately 1.45pm, landing officer 3 began to unlock prisoners from their cells on K4 for work. Those who did not have a job were left locked in their cells. Prisoner B, the friend of the man whose cell was a few doors away, was unlocked to go to work. CCTV footage of K4 landing shows prisoner B looking through the observation panel of the man's cell at 1.52pm for approximately 10 seconds. He can be seen waving his arms above his head, saying something and starting to run down the landing. He looks at the man's cell again and gestures with his hands across his neck. The landing officer then arrives at the man's cell in six seconds, opens the door and shouts for staff assistance which follows swiftly.

43. Landing officer 3 told police that after unlocking K4 landing, he was standing at the end of the landing furthest from the man's cell when he saw prisoner B beckoning to him, shouting "Boss, Boss." He walked towards his who then motioned with his hands as if someone in cell 26 was hanging himself. The officer then began to run, looked through the observation panel and unlocked the cell whilst shouting for help from staff.

44. Landing officer 3 said he went into the cell and tried to lift the man in a bear hug to relieve his weight on the noose. Landing officer 4 arrived within seconds and lifted the man's legs, which he thought might have been by the heating pipes, off the floor. The officer loosened the bed sheet which was tied around the man's neck. He described the skin as cold to the touch. Landing officer 2 ran to the man's cell and saw landing officer 3 and landing officer 4 holding up the man, who seemed slumped. He thought that the man's feet were touching the floor. His complexion looked normal, not blue. Landing officer 2 assumed momentarily that they were restraining him until he noticed a bed sheet tied around the man's neck that was still attached to the window bars. He jumped on to the toilet and undid the ligature from the window. The

man was laid on the floor. Landing officer 2 gave landing officer 4 a face mask so that he could begin mouth-to-mouth resuscitation. Landing officer 2 began chest compressions and then checked for a pulse but did not find one.

45. At 1.55pm, Manchester's Emergency Control Room issued a radio message to alert staff to a medical emergency. At 1.56pm, an emergency ambulance was called. Landing officer 2 and landing officer 4 continued CPR for several minutes until the principal officer (PO) and the duty nurse arrived from the healthcare centre and took over.

46. At 2.04pm, the Manchester's General Practitioner who was on duty when the alert was raised, arrived at the cell and checked the man for signs of life. There was no palpable carotid pulse, his pupils were fixed and he was not breathing. Staff told the doctor they had begun CPR at 1.50pm and he asked them to continue. At 2.11pm, after checking for signs of life, he pronounced the man dead. The two ambulance crew, who had arrived at 2.08pm provided the GP with an Electrocardiogram (ECG) rhythm strip to confirm the man's death.

47. Greater Manchester Police arrived at 2.45pm in order to take statements from staff, examine the man's cell and satisfy themselves that his death was not suspicious.

48. A post mortem was conducted on 10 October 2006 by a pathologist. It found "a small linear abrasion on the right side of the man's neck and a fracture in the left side of his larynx ... these findings were entirely consistent with pressure on the neck caused by a soft ligature, like a bed sheet … There were no other injuries on his body, which might have suggested that he had been assaulted. There was significant natural disease in his body, in form of severe narrowing of his coronary arteries. Though this had the potential to cause heart failure at any time and could, in theory, have contributed to or accelerated his death by reducing his cardiorespiratory reserve, in my opinion there is no doubt that the underlying cause of his death was pressure on the neck. Toxicology showed that there was no alcohol, common drugs of abuse or medicines in his blood or urine."

49. According to the chaplaincy log, at 2.15pm the duty chaplain at Manchester was told of the man's death. At 2.25pm, she telephoned the Imam at Manchester. Although it was the Iman's day off, he agreed to break the news of the man's death to the family. At 2.45pm, he was given the telephone number of the man's brother-in-law whom the man had named as his next of kin. The Imam telephoned Manchester at 3.15pm to say that he had told the family the distressing news of the man's death. At 3.40pm, the Iman telephoned again to say that he had obtained the address of the family (it was a family he knew) and was on his way to see them.

50. My family liaison officer and the lead investigator visited the man's aunt to learn of the family's concerns. Assisted by a close family friend, she said the family was unable to accept that the man had taken his life during Ramadan. She explained that, as a Muslim, he knew that Ramadan was a sacred period and taking his life would be considered a great sin.

51. The family was concerned that the Imam had broken the news of the man's death to them over the telephone before visiting. They understood that the Imam worked at the prison but were also expecting contact from a governor or support worker. This had not taken place and they felt as if they had not been given adequate recognition as a bereaved family.

52. They acknowledged that they had been offered and accepted the opportunity to visit the prison to see where the man had died. However, despite having spoken to staff on duty when the man had been found, they had been unable to speak to prisoner B (the prisoner who had found the man) or other prisoners who knew him. They had since found out that prisoner B had been released from prison before they had the opportunity to talk with him. They also wanted to meet with prisoner A, who had shared a cell with the man, to learn more about how the man had coped in prison.

53. The man's family felt that the prison visit left them feeling there were too many discrepancies surrounding the man's death. They were still unclear about exactly how the man was found and what had happened afterwards. They had asked whether any photographic evidence had been recorded by the police but were told by prison staff that they did not know. They had wanted to see the bed sheet the man had used as a ligature but were told they could not. It was not explained to them why not. They were mystified that the man had been described as "hanging" from the window yet he was a tall man (almost six feet in height). They could not see how the window opened and it did not seem high enough from the ground for this to be possible.

54. The family had sought information from the local police who told them they were "too busy" and were unable to offer any assistance. This made them feel helpless. This lack of information was interpreted by the family as undue reticence and fed their suspicion that they had not been given adequate information about the circumstances surrounding the man's death. As a result, the man's aunt had expressed her concern to her local Member of Parliament who, in turn, made contact with my office.

55. The lead investigator undertook to find out whether prisoner A wished to meet with the man's relatives. Prisoner A said he was willing to meet with them if the prison would organise it.

56. My investigators asked the Imam to clarify his contact with the family. He said that, although he had agreed to tell the man's family of his death by himself, it was the first time he had assumed the duty to see a family of a person who had apparently taken their life in HMP Manchester. He had undertaken the task without another member of staff. This was not the usual practice, but he had agreed to do so as he felt comfortable and was not unduly concerned about issues of security. He knew the man attended Muslim services in the prison, and had come into contact with some members of the man's family previously in his capacity as Imam at a local mosque (although not the one attended by immediate members of the man's household). After the funeral had taken place, the family told him they had concerns about his death and wanted to talk to prisoner B. The Imam did not think that arranging for them to meet prisoner B was a task he should be involved in. He told the family that my office would be conducting an investigation and advised them to obtain a solicitor if they had concerns.

57. On 7 February 2007, my investigators raised separately with the Imam, the second PO and the governing Governor, the family's concern about not having met either prisoner A or prisoner B. It was the Governor's understanding that Manchester had written to prisoner B at a local address after his release but he had not replied. When my investigators checked the Prison Service's Inmate Information System for prisoner's B intended address on release, it was recorded as "Third Avenue, London" which was insufficient for him to be traced. My investigators have since obtained his full address and passed this to the man's family. Although they asked Manchester prison to arrange an opportunity for the man's family to meet with prisoner A, as a matter of priority, the man's aunt contacted my family liaison officer in March 2007 to say that the meeting had not yet taken place and she had been asked to put her request in writing. My lead investigator contacted Manchester to ascertain why this was so when she had said explicitly in February that it would be desirable for the family to be able to meet with a prisoner who could answer their questions about the man. She received a reply from the second PO that "a letter has been drafted in response to the correspondence from the man's aunt" I understand that a meeting with prisoner A has not taken place.

58. A clinical review into the healthcare received by the man whilst in custody was conducted by the Acting Head of Nursing, South Locality, Manchester Primary Care Trust. Regarding notes that the man's English was poor, she concludes:

59. "… there is no indication that translation services were used to support any consultation with the man; further, it is unclear as to the status of his English comprehension. It cannot be established that the man clearly understood that he should take prescribed medication for 28 days, nor that he had to return to see the doctor on 18 September 2006."

60. Allied to difficulties with communication, although the reviewer concedes that both a nurse and a prison doctor said they would use Language Line if they felt it necessary:

61. “There appears to be a reliance on the ability and willingness of other prisoners to act as interpreters: however, this is a breach of patient confidentiality that would not be acceptable in any other Primary Care service.”

62. The clinical reviewer also notes that the man would have benefited from a substance misuse assessment and a mental health assessment but neither were conducted. A secondary health screen should have been undertaken within five days of the man’s reception into prison but one was not carried out either at Forest Bank or Manchester.

63. Section 4.53 of the report by Her Majesty’s Chief Inspector of Prisons, of the unannounced inspection of Manchester in 2004 says, “If a prisoner fails to attend an appointment, healthcare staff should identify why this has occurred and re-arrange the appointment if necessary.” In the man’s case, this did not happen.

64. The clinical review concludes:

65. “It is clear that the man did not receive the level of health assessment required for each prisoner. He did not undergo a secondary health screen or a mental health review. I cannot say that the man fully understood his role in managing his health, as there is a suggestion that his spoken English was poor.

66. “I cannot say that these omissions resulted directly in the death of this man: however, had he undergone the further assessments required, these would have been additional opportunities to better understand his mental state and provide relevant treatment or therapy.”

67. My investigators asked HMP Manchester for copies of their records concerning the use of Language Line in the months preceding the man’s death. They were told that Manchester was unable to access the relevant information as it was not held in the establishment or readily obtainable.

68. After visiting the man’s family to discuss his death, the Imam drove back to Manchester. He spent some time talking with prisoner B, who was still very shocked at seeing the man suspended, and the prisoners on K wing who knew the man. Two officers also spoke to prisoner B to assess whether he might be at risk of harming himself as a result of what he had witnessed earlier.

69. Prisoner A attended court on the day of the man’s death. On his return to Manchester some days later (after being sent to HMP Preston), he

was told that the man had apparently killed himself. He told my investigators that he was very shocked and could not sleep for two or three days. Initially, he could not think of anything the man had said to indicate he might harm himself. However, at interview, he recalled that four or five days before his death the man had returned upset from a legal visit with his solicitor. The solicitor had apparently told him that, after serving a life sentence, he would be deported. The man was very upset and had said to prisoner A, "my life is finished, my family is finished, everything is finished." The man woke up during the night on several occasions that week and asked prisoner A about his life. Prisoner A tried to console him by saying he would only serve six to eight years, but thought the man might have been worried about the number of years he would have to stay in prison if convicted.

70. The man's family agreed that he was concerned about the sentence he faced. He had been anxious about his court case and did not have a good understanding of the criminal justice system. It was his first time in prison and he had received conflicting information from people giving him differing advice on how many years he should expect. His ex-wife had told his solicitor that he was depressed. They had mentioned arranging for him to have a psychological assessment but his family was unsure whether this had happened.

71. My investigators spoke to Manchester's diversity manager and the race equality officer. The race equality officer was asked what the main issues concerning race were on K wing. He said that staff had reported that they were being accused of being racist. He was not aware of any Black or Minority Ethnic officers working on K wing. The race equality officer said that he had asked the Education department to incorporate how to complain about a racist incident into the course for English for Speakers of Other Languages. It was also part of the induction process. He acknowledged that the complaints system for reporting a racist incident could seem cumbersome to prisoners, but unless a complaint was made formally he would be unable to bring much pressure to bear.

CONCLUSIONS

72. From the time the man entered first police then prison custody, staff commented on documentation that he had difficulty with English. The words “poor English” crop up regularly, yet no assessment was carried out of his needs beyond the induction period. There are comments in his Record of Events implying he could understand more English than he appeared to. These suggest an assumption that, because the man could speak some English, he had a comprehensive grasp of the language. On the other hand, induction staff on G wing had recognised his limitations yet had managed to communicate with him in a positive way. This progress appears not to have been followed up elsewhere.

I recommend that, where a need for education has been identified on induction at Manchester, this is followed up by an assessment by the education department.

73. The man had seen a doctor on 15 August who wrote in his notes that his poor English made it difficult to obtain a comprehensive history. However, there is no evidence that any healthcare staff used Language Line so that they could communicate effectively with him. I am surprised that a more structured translation service does not seem to be in place. I was also struck that my investigators were unable to obtain from Manchester details of when Language Line had been accessed by staff, by whom and which languages had been requested. The facility exists so that staff can address the needs of prisoners in their care and should be used when the need arises.

I recommend that the Governor in partnership with the Primary Care Trust devises a system for the effective use of Language Line in communicating with healthcare patients.

74. I am concerned that the man did not receive a mental health assessment. The medical notes from Forest Bank contained the words “mental health review” but there is no evidence that this was done. Manchester did not check whether the assessment existed and did not ask for one to be carried out. This is all the more surprising given that prisoners charged with murder usually have an assessment as a matter of routine.

I recommend that the Governor and the Primary Care Trust put a system in place to ensure that mental health assessments are carried out at the earliest opportunity for prisoners charged with murder.

75. On 10 and 15 August, the man had told doctors that he was feeling depressed. Whilst he was prescribed medication, his depressive feelings were not explored. When he was booked to see a doctor and did not turn up, this was not followed up. It should not be taken for granted that a prisoner who does not attend a medical appointment has

always made an active decision not to do so. It is possible that they may not be aware of it or may have another activity scheduled at the same time such as a court appearance or a visit. Unlike in the local community, the free movement of prisoners in Manchester is limited. It is the prison's responsibility to enquire why an appointment has not been kept and, if necessary, to arrange an alternative appointment.

I recommend that the Governor and the Primary Care Trust devise a protocol to ensure that missed medical appointments are followed up.

76. Police records which included medical documentation about the man's time in police custody were contained in his security file which is not accessible to non-security staff. Relevant information should have been copied to healthcare and kept in his clinical record. If this had been done, HMP Manchester would have had more readily available information that the man had harmed himself in the past, that he injured himself when frustrated and upset, that he suffered from alcohol-related problems, that he felt mentally tired and that he had previously been given anti-anxiety medication.

I recommend the Governor ensures that health-related information from police custody held in security files is also copied into a prisoner's clinical record.

77. The man had been charged with murdering a close friend. His cellmate described a person who spent most of his time in bed not talking or associating with prisoners and feeling down. These are common signs of depression. K wing staff seem not to have been aware of his behaviour, just seeing him as one of the "quiet prisoners" or not noticing him at all. Both prisoner A and prisoner B said that they found it difficult to approach officers and alluded to the fact that Asian prisoners felt marginalised on the wing. I am troubled by the perception, rightly or wrongly, that some Asian prisoners did not feel K wing was inclusive and that staff said they in turn had been accused of being racist. Although Manchester is one of the largest prisons in England and Wales, and is situated in an urban community which has a significant Black or Minority Ethnic population, the numbers of BME officers are very low despite attempts at recruitment. This is in some contrast to prisons in London.

I recommend the Governor satisfies himself that the culture of K wing is positive and inclusive towards prisoners of all ethnic backgrounds.

78. After the man died, his family expected a senior manager to follow up the Imam's initial contact. When this was not done, they felt sidelined. It is regrettable that the family interpreted their limited contact with Manchester as signifying that the man's death was not regarded as important. It would have been good practice early on for Manchester to

have found out the answers to their concerns about the circumstances of the man's death. It is regrettable that Manchester did not arrange for the family to meet the prisoner who found the deceased. Relationships between prisoners are important and such a meeting may well have been helpful for prisoner B who was understandably distressed at seeing his friend dead.

79. Manchester had an opportunity to re-establish family contact on a more positive footing by facilitating a meeting with the man's cellmate, prisoner A. It is entirely natural that the family would have wanted to meet other prisoners who knew the man. I am disappointed that the man's aunt was asked to put in writing her request to see prisoner A some five months after the man's death. This was despite my investigators making it clear on more than one occasion that such a meeting was desirable. A meeting should have been arranged as a matter of priority.

I recommend that the Governor ensures that, in future, bereaved families are given an opportunity to meet prisoners who were friends of their loved one.

80. Although the Imam was willing to take responsibility for informing the family of the man's death, it was the first time he had undertaken a family liaison role. It is more usual for a member of the chaplaincy team to break the news of a death with another member of staff, rather than alone. This is not necessarily an issue of security. It reflects the importance that a prison attaches to good family liaison and increases the chances of being able to answer any immediate questions the family may have.

81. The man's family was told of his death within an hour of it occurring. In itself this was a good thing and I can understand Manchester wanting to tell them the distressing news as soon as possible. Nevertheless, it might have been beneficial to have involved a member of staff who had attended the hot debrief and who was better equipped to answer any questions the family had about the circumstances.

I recommend that initial visits to bereaved families are conducted by more than one member of staff.

82. Notwithstanding the concerns expressed by the man's family, all the evidence suggests that he took his own life. And with the benefit of hindsight, it is clear that he was much more at risk than staff at Manchester had appreciated. Busy local prisons are not the easiest environments for staff to get to know those in their care. This is particularly the case if there are language barriers, or if particular groups of prisoners perceive (rightly or wrongly) that staff are not sympathetic to their needs.

LIST OF RECOMMENDATIONS

I recommend that where a need for education has been identified on induction at Manchester, this is followed up by an assessment by the education department.

I recommend that the Governor in partnership with the Primary Care Trust devises a system for the effective use of Language Line in communicating with healthcare patients.

I recommend that the Governor and the Primary Care Trust put a system in place to ensure that mental health assessments are carried out at the earliest opportunity for prisoners charged with murder.

I recommend that the Governor and the Primary Care Trust devise a protocol to ensure that missed medical appointments are followed up.

I recommend that the Governor ensures that health-related information from police custody held in security files is also copied into a prisoner's clinical record.

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