Investigation into the circumstances surrounding the death of the man at HMP Albany in October 2008

Report by the Prisons and Probation Ombudsman for England and Wales

August 2009

This is the report of an investigation into the death of a man. He was found hanging in his cell at HMP Albany on 27 October 2008 and was pronounced dead by the prison doctor shortly afterwards. He had been in custody for six months.

I would like to offer my personal condolences to the man's family, friends and everyone affected by his death.

The investigation was undertaken by my colleague. In addition, a doctor was appointed by the Primary Care Trust to undertake a review of the man's clinical care, and I am grateful for his contribution to my investigation. I must also thank the Governor of Albany and his staff for their participation.

Having received a 15 year sentence for sexual offences, the man transferred from HMP Winchester to Albany to commence a Sex Offender Treatment Programme (SOTP). He was described by staff as a quiet individual who gave them no concern. However, in August 2008 a fellow prisoner became anxious about the possibility of the man harming himself and alerted prison staff. Yet when staff spoke to him, he denied having any thoughts of self-harm. He was reminded that support was available from staff and Listeners should he ever wish to talk. He was also provided with an appointment slip to complete to see the prison doctor as he said he was not sleeping well. After this, he raised no issues or concerns, and staff did not detect any signs that he intended to harm himself.

On the evening of 26 October 2008, there were no problems noted about the man when he was checked upon during the evening roll check. The next morning, he was discovered hanging by a member of staff conducting the subsequent roll check. Letters were found in his cell, the content of which clearly indicates his intention to take his own life.

My report includes four recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman **August 2009**

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SUMMARY

The man was arrested in March 2008 for serious sexual offences. Two days later, he appeared at the Magistrates Court and was remanded into custody and transferred to HMP Bullingdon. In April, after pleading guilty, he was convicted. He was transferred to HMP Winchester before later being sentenced to 15 years imprisonment. The court recommended that he undergo a Sex Offender Treatment Programme (SOTP) whilst in custody.

The man was then transferred to HMP Albany on 28 July, as a space on the SOTP had become available. From the time of his arrival in Albany he was described by staff as a quiet individual who gave them no concern. He completed his prison induction without any problems.

During August 2008, the man had a number of conversations with a fellow prisoner in which he talked about harming himself. The prisoner became concerned and told staff that he was worried about him. However, when staff spoke to the man about his well-being, he said that he had no problems except that he had not been sleeping properly. Staff reminded him of the support networks available to him, and gave him an appointment application so that he could ask to see the doctor. He gave no indication of wanting to harm himself.

The man was seen by the prison doctor approximately three weeks after he submitted his appointment request. During this time, no concerns had been raised about him by wing staff. The doctor prescribed medication for his sleeping problem and for back pain, but raised no concerns about his mental state.

On the morning of 27 October, the man failed to respond to the officer conducting the morning roll check. Staff entered his cell to discover him sitting by the window with the curtain covering the top half of his body. When the curtain was pulled back, he was found hanging from the window. He was lowered to the floor where staff examined him but found no signs of life. As his body was cold and rigor mortis was present, they rightly decided that cardio pulmonary resuscitation (CPR) would not be attempted.

This report includes four recommendations.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened by one of my investigators, on 29 October 2008 when he visited Albany. He met the Governor and some of his staff. Notices of the investigation and terms of reference had already been sent to the prison, and these invited anyone with any information to contact my investigator. As a result, my investigator interviewed one prisoner.

2. My investigator also met the Head of Healthcare and representatives of the Prison Officers' Association. He visited all parts of the prison including the wing where the man had lived, and met the Chair of the prison's Independent Monitoring Board.

3. The man's prison records, including his medical record, were made available to my investigator during his initial visit to the prison. A full set of documents were given to him, already clearly ordered and filed in a ring binder, which he found extremely helpful. Additional documents were made available when he returned to conduct interviews.

4. A clinical review was commissioned from the local Primary Care Trust (PCT) to assess the man's medical care. I am grateful to their consultant for his review.

5. One of my family liaison officers (FLOs) made contact with the man's ex-wife, informing her of the investigation. His brother and his wife also took an active role in dealing with the prison in the immediate aftermath of the man's death. They were out of the country for much of the investigation but will be given an opportunity to comment on the draft report. The man's family provided my FLO with some further insight into how he felt whilst in prison:

    - The family described the man as a very sociable, gregarious man who was extremely popular in his local community before going into prison. They believe he realised that he could never really return, and this would have weighed heavily on his mind. He had begun to feel the burden of his offending and was thinking rationally about a bleak future.

    - Compared to previous prisons the man had been in, the family believed that he had completely changed when he moved to Albany. They had visited him on at least three occasions and said he had settled well and was in a more relaxed and constructive environment.

    - The man had spoken to family members by telephone a few days before he died but gave no indication of wanting to harm himself.

    - The family felt the man chose to take his life in a planned and deliberate way. He left letters in his cell for his son, his brother and

his girlfriend in which they felt he clearly said goodbye. They wished to know how he had learnt how to take his life in the manner that he did.

HMP ALBANY

6. Albany is a category B training prison situated near Newport on the Isle of Wight. It opened in 1967 on the site of a former military barracks. Albany offers a varied regime with education and several offending behaviour programmes.

7. At the time of the man’s arrival, the prison could hold up to 567 adult male prisoners. The average age of Albany’s population is high when compared to most jails.

8. There are five wings (A – E) which are almost identical. Each wing holds between 94 and 96 prisoners in single cells with in-cell power and access to electronic night sanitation (the cell door unlocks for a limited time to allow the prisoner to go to the toilet). There are three small ‘spurs' on each landing, with communal recesses containing showers, toilets and wash basins. There are also two 40 bed units (F and G) which comprise single cell accommodation with en-suite facilities.

9. Health services at Albany and at the other two prisons on the Isle of Wight are commissioned by the local NHS Primary Care Trust. The prison’s healthcare is clustered with Camp Hill and provided by Parkhurst. In total, Parkhurst provides healthcare to 1,500 or so prisoners on the island. Prisoners’ daily medical needs at Albany are met by way of out-patient clinics and core day primary nursing cover. There are three nurses on duty from 7:30am to 5.30pm during the week. At weekends and during evenings, one member of healthcare staff is on duty. GPs from Medina Healthcare, a local community practice, attend Albany for three-hour sessions four times each week. Evenings and weekends are covered by on-call GPs from the local PCT. There is no nursing or healthcare cover based at Albany during the night.

10. Since April 2004, when my office became responsible for investigating all deaths in prison custody, there had been no previous self inflicted deaths at Albany.

11. From 1 April 2009, the Prison Service officially launched HMP Isle of Wight, clustering Albany, Camp Hill, and Parkhurst. The amalgamated prison holds approximately 1,700 prisoners on the three sites with a central administration.

HM Chief Inspector of Prisons’s report

12. The most recent report on Albany by HM Chief Inspector of Prisons followed a full announced inspection in November 2007. The Chief Inspector noted that public protection and the range of activities provided were good. Offending programmes were also of a very high standard. However, the Chief Inspector noted that relationships between staff and prisoners were distant and mistrustful. There were insufficient work

places, and systems to protect prisoners against bullying and self-harm were not sufficiently robust.

Independent Monitoring Board (IMB) report

13. IMB members are lay people appointed to each prison by the Secretary of State for Justice to monitor the treatment of prisoners. They are not members of the Prison Service, nor are they part of the prison's management team. They are required to report annually to the Secretary of State, highlighting good practice and any areas of concern.

14. The IMB report for HMP Albany for the period 2007-08 said that existing healthcare services within the prison were stretched to capacity, largely due to the age of the prison's population. This could at times lead to missed hospital appointments, and delays in issuing medication from the pharmacy in Parkhurst. The report said that Albany had a very pro-active Safer Custody and Suicide Awareness policy in place with strong prisoner involvement.

Assessment, Care in Custody and Teamwork (ACCT)

15. As at all prisons, ACCT has been introduced at Albany to monitor and support prisoners assessed as being at risk of suicide or self harm. (The previous system was known as the F2052SH procedure.) Once placed on ACCT, the prisoner is observed at pre-determined intervals according to the perceived level of risk. At ACCT plan review meetings, a prisoner's level of risk can be reviewed and noted as either 'Low, Raised or High' depending on the level of concern.

Cell Sharing Risk Assessment (CSRA)

16. In order to make sure that unsuitable prisoners do not share cells (for example, locating a racist prisoner together with one from a visible ethnic minority, or a mentally disturbed prisoner with a violent one), a cell sharing risk assessment form is completed by reception when a prisoner is first admitted.

Induction

17. Induction is the process of introducing new prisoners or newly sentenced prisoners into custody. It is designed to explain the immediate consequences of being in custody. Staff will also explain the routines and procedures of the prison, and any rules and regulations that must be observed. The induction period includes sessions with various agencies such as Mental Health In-Reach Team, the chaplain, probation and CARATS. Staff check that prisoners understand what is going to happen to them and attempt to deal with any immediate problems.

Listeners

18. Listeners are prisoners trained by the Samaritans to provide a listening ear for their peers. Like Samaritans, they do not offer counselling but are there to offer support particularly for prisoners at risk of self harm. The service is confidential.

National Offender Management Information System (C-NOMIS)

19. This is a national computer database introduced in prisons to improve data holding, and sharing of information. The first release (and pilot) of C-Nomis took place at HMP Albany.

Personal officer

20. Although the personal officer scheme in operation at Albany is not mandatory, every prisoner is normally assigned a personal officer. Their role is to meet the prisoner on a regular basis and to discuss any issues or concerns the prisoner may have.

KEY FINDINGS

Prior to the man's arrival at HMP Albany

21. Following the man's arrest on 26 March 2008, he was held in police custody for two days when he appeared at the Magistrates Court, charged with serious sexual offences. He was remanded into custody and transferred to HMP Bullingdon, arriving there at 5.41pm. He received a full prison induction and was assessed by prison and healthcare staff. A cell sharing risk assessment (CSRA) was completed and he was assessed as a "low" risk. (He remained a "low" risk throughout his imprisonment.)

22. The man remained at Bullingdon for ten days. No concerns were raised about his well-being during his time there.

23. On 7 April, the man was convicted after entering a guilty plea. He was transferred to HMP Winchester to await sentencing. When he arrived at Winchester, he repeated the prison reception process. Due to the nature of his offences, he requested vulnerable prisoner (VP) status and was duly located to the VP wing. He received his induction into the prison regime and procedures and appeared to settle into prison life. Comments in his wing history sheet ranged from "a quiet individual who is polite, no concerns with this prisoner" to "prisoner has no issues to raise, stated fine no problems".

24. At the Crown Court on 19 May, the man was sentenced to 15 years imprisonment. The court also recommended that, while in custody, he should undergo a Sex Offender Treatment Programme (SOTP). He was transferred from Winchester to HMP Albany on 28 July as a space had become available for him on the SOTP.

The man's arrival at HMP Albany

25. The man arrived at Albany around 2.41pm. When he was handed over by the escort staff to Albany reception, no concerns were raised about his well-being. He went through the reception process again and was seen by reception officers who explained Albany's procedures and rules. A senior officer (SO) was on duty the day that the man arrived. He told my investigator that he would interview all prisoners for approximately 25 minutes when they first arrived to obtain their details and confirm their well-being. The man denied that he had any history of harming himself and, in response to a standard question, said that he had no thought of harming himself. The reception SO assessed him as a low risk prisoner and his cell sharing risk assessment document was noted accordingly.

26. Later that day, the man was also assessed by a healthcare officer. His blood pressure and weight details were checked and the man said that he was moderate smoker. On the 'Physical activity readiness questionnaire', he said he suffered from slight back pain. No other

concerns were noted by reception staff. He was located onto A wing, to receive his prison induction.

27. At interview with my investigators, an officer confirmed that he worked on A wing when the man arrived at Albany. The A wing officer described him as “very quiet, kept himself to himself and was polite”. He gave staff no cause for concern.

28. A fellow prisoner told my investigator he had several conversations with the man as their cells were close together on the same spur on A wing. The man often ate his meals in his cell with him. He described him as a quiet man, but one who had talked about killing himself - specifically by hanging. At first, the fellow prisoner had no great concern about him, saying that many prisoners would talk about such things but not actually carry out the act. However, as the man spoke more about harming himself, the detail of how he would do it became more specific. As a consequence, the prisoners concerns for the man’s well-being increased, and on 20 August he reported them to the man’s personal officer.

29. The same day, at the request of the personal officer, the prisoner’s concerns were followed up by another senior officer (SO) accompanied by an officer. The SO told my investigator that his conversation with the man was quite in-depth, and he reminded him of the support of staff and the Listeners. The man explained that he had good and bad days, and was not sleeping very well. However, he said that he was okay: he had a son and partner and was looking forward to them visiting him in prison.

30. The SO said that he “felt confident” having spoken to the man that there was no need to open an ACCT document. He did, however, provide him with a healthcare application form to complete to see the doctor regarding his sleeping problem.

31. The prisoner told my investigators that the man knew what to say to the officers to allay any concerns they might have had about him. He said the man felt as if there was nothing left for him, and had said he was having sleeping problems and “could not cope”. The prisoner told him to see the prison doctor.

32. According to the medical appointments database records, the following day (21 August) the man submitted his healthcare application form to the healthcare department to request a doctor’s appointment. In general, if a prisoner says their need is urgent or important, they are seen quickly. Otherwise, appointments are treated as routine, with a delay at the time of approximately three weeks.

33. On 12 September, the man attended a doctor's appointment. He was examined by the primary care consultant, who was a locum doctor who did not permanently work at the prison. His assessment of the man was recorded on the computerised medical record system (known as VISION).

34. In a statement provided as part of the clinical review for this investigation, the primary care consultant said that he examined the man in an out-patient clinic at the prison. He told him that he had a history of back pain. He also complained of not sleeping properly (insomnia) because of issues with his partner, although when asked he gave no further information. The doctor prescribed zoplicone (commonly used for insomnia) and ibuprofen and anusol cream. The primary care consultant said that the man maintained good a rapport during the consultation and he had no cause for concern about his mental state.

35. The man was moved to B wing (B3 -13), a normal residential wing, on 20 September. A B wing officer told my investigator that he was the wing officer in charge of movements and, if a prisoner had a problem, he was often their first point of call. When the man arrived on the wing, he welcomed him and went through the wing induction procedures. The B wing officer described him as a mature man who was compliant, polite and respectful. He never approached the B wing officer to raise any concerns.

36. According to C-NOMIS, the man was allocated an SO as his personal officer when he was transferred to B wing. The B wing SO said he was unaware of this as it was not brought to his attention. He also said that senior officers were not allocated personal officer duties so he was unsure why his name was entered on the computer system.

37. The B wing officer told my investigator that the system on B wing for allocating personal officers used to be based on cell numbers, so each officer knew they were the personal officers for specific cells. However, the system was being revised at the time of the man's arrival and was in some confusion. Personal officers were allocated to prisoners and not cells, so wherever they moved the personal officer stayed the same. Although the prison has now reverted back to the old system (so personal officers are allocated by cell number), at the time he was not allocated a personal officer.

38. My investigator found very few entries on the man's computer wing history sheet (C-NOMIS) referring to his well-being. The B wing officer said the man worked in the woodwork workshop in the mornings and afternoons every week day. No concerns had been raised by staff in the workshop.

39. Prison records made available to my investigator show that the man made a telephone call to a friend on 24 October, and then to his sister-in-law on 25 October. He did not suggest in either call that he intended to harm himself. In fact, as his telephone conversation with his sister-in-law came to a close, he told her he would ring in a week's time. (The content of these telephone calls only became known to the Prison Service after the man's death.)

Events on 26 - 27 October

40. Another prisoner provided my investigator with a statement about a conversation he had with the man on Sunday evening (26 October). He said that the man approached him around 3.00pm in the communal area of their wing. They chatted for while and he asked the other prisoner if he had any puzzles. Although he did not have any, they continued to talk for a few minutes before he returned to his cell. The other prisoner said that the man was "quiet and did not seem distressed in any way".

41. Later that evening, an operational support grade (OSG) arrived to commence his night duty shift. At interview with my investigator, he explained that staff would rotate approximately every eight weeks onto a different wing. On this particular set of nights, he was on B wing and started his night duty shortly before 8.00pm.

42. The OSG said that, after collecting his radio and receiving a handover from the day staff, he commenced his roll check of B wing (all single occupancy cells). He said he did this by "rattling the door" to get a response. The OSG explained that 90 per cent of the time the prisoner would respond, and he always also checked the cell by looking through the cell observation flap. However, he said that the man was the kind of prisoner who did not respond. He would just turn his head and look at the officer conducting the check to acknowledge him.

43. The OSG said this was exactly what the man did on this night. He was in his cell standing up watching television. When the cell flap opened, he turned his head, glanced at him, and then turned his head back to the television. The OSG said he had no concerns about him at the time.

44. The following morning, the OSG began the morning roll check at around 5.30am. He started by checking prisoners on the fourth landing and made his way to the third and second until he arrived at his cell at around 5.40am.

45. The OSG said that, given the time of morning that the roll check takes place, staff generally try not to make too much noise. As he looked through the spy observation hole of the man's cell, he noticed a curtain or sheet hanging down from the window. He also thought he could see

him sitting behind the curtain with his face obscured. The OSG immediately turned on the cell light and looked through the observation panel of the cell door to gain a better view. He saw that the man's feet were on the floor, the bottom part of his chest was showing and his left arm appeared to be inside his tee shirt. He called his name, flicked the cell light on and off and rattled the door to get a response. He did not respond. Wanting to be discreet, the OSG then proceeded to the wing office (which was only seconds away) to telephone the Control Room to tell the SO in charge of the prison, what he had seen.

46. The SO in charge of the prison told my investigators that no concerns had been raised during the night shift and he visited A wing at around 10.00pm as part of his routine check. When he was contacted by the Control Room in the morning, he was at the furthest point in the prison away from B wing. He asked what type of incident had occurred. After being told that it was an emergency, he asked the Control Room to send two officers to B wing immediately, and said that he would follow as soon as possible.

47. At interview with my investigator, the duty governor confirmed that Albany did not use any specific codes in emergencies. He explained that it could be difficult to use an open communication device like a radio without giving too much information to any nearby prisoners. If an alarm needed to be raised, the expectation was that an officer would use the office telephone to contact the Communications Unit if they were in an area with other prisoners. Otherwise, staff would use their radios.

48. The A wing officer told my investigator that he begun his night duty around at 8.30pm. The following morning (Monday 27 October), the A wing officer commenced his roll check at around 5.30am. Soon afterwards, he heard the Control Room relay information regarding an unresponsive prisoner on B wing. After a couple of minutes, the A wing officer received a call for him to attend B wing, which he did immediately. He was aware that it might have been necessary because, if a prisoner needed to be unlocked at night, three members of staff are required to be present.

49. When the A wing officer arrived on B wing, another officer and the OSG were outside the man's cell. The two officers updated him on the situation and, having looked through the cell observation panel, the A wing officer immediately told the other officer to contact the Control Room to unlock the cell (which was secured with a remote electronic locking system) and call the SO in charge of the prison.

50. The officers went in the cell. The television was on and the man was sitting by the window. The curtain was covering the top half of his body. The A wing officer pulled the curtain back and saw the man hanging from the window. He had ripped strips of bed sheet to use as a ligature. The A wing officer raised the man's body to release some of the tension on the ligature whilst the other officer used his cut down tool to cut the

ligature. He was then put in the recovery position. The A wing officer checked for any signs of life, but could not find a pulse. He said that the man's eyes were glazed, he was cold and stiff, and rigor mortis had set in. Although not being first aid trained, the A wing officer said that he thought the man appeared to be dead. He said that the OSG and other officer concurred and therefore cardio pulmonary resuscitation (CPR) was not attempted.

51. The SO in charge of the prison arrived at B wing within minutes of being notified, and was briefed by the staff who had gone in the man's cell. Although he himself did not enter the cell, he looked in and, in interview, described him as being colourless. He believed that he had been in the same position for some time. The SO ensured that the cell was sealed to preserve evidence and contacted the Control Room to instigate the death in custody contingency plans. An ambulance was requested immediately. While he awaited the arrival of the ambulance, the SO checked on the welfare of those staff present.

52. The paramedics arrived at 5.50am and were escorted to the man's cell. They examined him for signs of life but found none. Although they confirmed his death, they did not have the authority to pronounce death and so the prison duty doctor was contacted and asked to attend the prison. The A wing officer said the paramedics believed the man had been dead for at least five hours.

53. Having been contacted by the Communications Room, the duty governor arrived at the prison at 6.25am, together with the police. They were briefed and attended the man's cell. 'Suicide notes' were discovered in the cell and handed to the police, who also interviewed the officers who had responded to the emergency.

54. Arrangements were made to identify the man's next of kin. Shortly afterwards, the duty governor held a Hot Debrief meeting with all staff who had been involved in discovering the man, and officers completed incident statements. The Care Team were notified and offered support to staff.

55. The prison doctor arrived soon afterwards and, following an examination, the man's death was pronounced at 7.17am. The doctor told the duty governor that, given the condition of the man's body, he had been dead for a number of hours. At 7.37am, the duty governor spoke to all the prisoners on B wing, offering support and reminding them of the services of the Listeners. The Samaritans were also informed of his death.

56. The man's next of kin was identified as his brother. After discussions with the Governing Governor and duty governor, a principal officer and a reverend were appointed as the family liaison officers (FLOs). They travelled to the man's brother's home area, arriving at 11.30am. Although they discovered that he was out of the country, they were able to contact and meet with his ex-wife, his son and his sister-in-law, who

were in turn able to contact his brother. The man's brother told his family that he would return to the United Kingdom to deal with matters surrounding the death. In his absence, the family were given all the necessary information from the FLOs. This included contact details and the offer of financial assistance with the funeral arrangements. The FLOs offered to visit the family again when the man's brother was present.

57. The following day (28 October 2008), the Governing Governor sent a letter of condolence to the man's family. The family later asked the revered to conduct his funeral, which was also attended by the duty governor.

58. Some weeks after the incident, a Critical Debrief meeting was held to discuss the man's death. The duty governor told my investigators that it was well attended by staff who thought it was a useful process. Prior to this, he had also sent each member of staff involved a letter reminding them of available support should they require it.

Post Mortem

59. The post mortem report has confirmed that the man's death was caused by "hanging". He was not under the influence of any drugs or alcohol. The report commented that there was no opportunity for active treatment to save him as his body was cold when discovered.

60. The pathologist described the ligature found in the man's cell as a folded piece of green fabric, the folds held in place with multiple irregularly spaced single threads tied with multiple turns and then knotted around the ligature. The pathologist comments that the ligature appears to have been fashioned with some attention and its appearance was similar to that used by fishermen when tying nets.

61. The man's ex-wife told my FLO that the prison had been very helpful and supportive to the family since the man's death and they appreciated the support they had been given.

ISSUES RAISED IN THE INVESTIGATION

Clinical Review

62. In his report, the clinical reviewer comments that the healthcare given to the man whilst in Albany was good and equivalent to the care he would have received in the community. Although the clinical reviewer makes three recommendations which will be shared with the PCT, I have not specifically referred to them in my findings here as they do not contain any factors relating to the man's death.

The doctors appointment system

63. There was a period of approximately three weeks between the man submitting an application to see a doctor and the actual appointment. The Head of Healthcare told the clinical reviewer that, at this particular time, there were delays in booking routine appointments. Ways of reducing delays were being considered. Healthcare were exploring the use of Pin Phones for patients to book their own appointments. This would ensure confidentiality and direct access to healthcare clinics, which could also reduce delays.

64. I do not believe that the time it took for the man to be seen by the doctor was relevant to his decision to take his own life. When he did see the doctor, he did not express any concerns about his mental health. The man was aware of the support networks available to him and raised no concerns with staff about his feelings.

65. I am pleased that the Healthcare Department are taking steps to improve prisoner access to the doctors' surgery, as it is important that even routine appointments are dealt with as quickly as possible.

Personal officer scheme

66. The man was not assigned a personal officer. This reduced the opportunity for staff to interact with him and be alert to any concerns or thoughts of harming himself that he might have had. It also meant that no regular comments about his well-being were noted in his prison records. The personal officer scheme, although not mandatory, is a fundamental part of caring for prisoners, and every training prison should be able to provide properly functioning arrangements.

    The Governor should ensure that the Personal Officer Scheme is operational throughout the prison.

C-Nomis

67. Albany had been a pilot site for C-Nomis for approximately 12 months when the man died. It appears that the transition from recording observations on paper to computer was difficult for some staff to

manage. My investigator found that his wing history sheet contained very little information. It is very difficult therefore for anyone now to gain a true picture of the man and how he was, or was not, conforming to life in prison.

68. The B wing officer told my investigator that staff found C-Nomis time consuming, and described the initial training as inadequate. The B wing SO concurred with this view, and felt that the introduction of C-NOMIS had affected the operation of the personal officer scheme.

69. C-Nomis has great potential as a tool to record information and assist in all aspects of prisoner care. It is now in the process of being rolled out to other prison establishments, and I am aware that the pilot programme at Albany is regarded as having been a success. This investigation has shown that this success was not an unbridled one, and for that reason it would be sensible if the Governor took stock once more. My recommendation is made with that end in mind.

    The Governor should remind staff of the use and purpose of use of C-NOMIS and where necessary provide further staff training.

Use of emergency codes

70. At the time of the man's death, Albany did not use any specific codes in emergencies. This contrasts with most prisons and with the experience of this office that the use of codes can quickly relay very specific information to the recipient and ensure a prompt and full response with the right equipment. This can especially be useful during night state when staffing levels are reduced. Although the use of a code in this instance would not have saved his life, I recommend that Albany introduces such a system into their emergency contingency plans as soon as possible.

    The Governor should review all relevant contingency plans and consider the introduction and use of emergency codes when alerting staff to such incidents.

Radio ear piece

71. When the man was discovered, the officer on duty raised the alarm by returning to the wing office to use the telephone. He did this despite having a radio, so that he could talk freely without other prisoners then becoming aware of what was going on. I do not criticise the officer's actions, which only took him seconds as he was very close to the wing office. However, it is important to reduce any delays when a possible emergency or life threatening situation has arisen.

72. My investigator raised this issue with the Governing Governor. He told my investigator that the prison had purchased radio ear pieces to be used with radios so staff could discreetly pass on information about

incidents they were involved with. Ear pieces had been made available to staff some time prior to the man's death, and the Governing Governor said that he would reissue a note to staff reminding them of its use. I therefore need do no more than bring this matter to the Governor's attention again.

First aid training

73. The first officers to arrive at the man's cell were confident that there were no signs of life. He was cold and rigor mortis had set in. When the paramedics arrived, they confirmed that he had probably been dead for several hours. Two of the officers who attended the cell, however, were not first aid trained. I have previously recommended in other investigations that first aid training is provided for all staff in contact with prisoners. I suggest that basic life support or first aid training should be reviewed for frontline staff at Albany to ensure that they are fully up to date with resuscitation procedures. Although sadly it would not have made a difference in this case, I believe this to be even more important for Albany because, during the night period, they do not have any healthcare staff on duty within the prison.

The Governor should review the need for first aid or basic life support training for staff on frontline duties.

CONCLUSION

74. The man had received a long prison sentence for very serious offences. He had been in custody for just over six months when he took his own life.

75. Whilst serving his sentence, the man was a quiet man and his interactions with staff were low key. I understand that these characteristics were in some contrast to how his family knew him when he was in the community.

76. Whilst at Albany, the man expressed no concern or distress to the staff. He did, however, confide in a fellow prisoner about possible ways he would harm himself. The prisoner rightly drew his concerns to the attention of staff who, in turn, responded appropriately. However, it would appear that he was intent on concealing his feelings from staff, and was successful in doing so.

77. I do not believe that staff at Albany could have predicted that the man had any intention of taking his life when he did.

RECOMMENDATIONS

1. The Governor should ensure that the Personal Officer Scheme is operational throughout the prison.

   The Prison Service has accepted this recommendation.

2. The Governor should remind staff of the use and purpose of use of C-NOMIS and where necessary provide further staff training.

   The Prison Service has accepted this recommendation.

3. The Governor should review all relevant contingency plans and consider the introduction and use of emergency codes when alerting staff to such incidents

   The Prison Service has accepted this recommendation.

4. The Governor should review the need for first aid or basic life support training for staff on frontline duties.

   The Prison Service has accepted this recommendation.