

**Investigation into the death in custody of
a man
at HMP Dartmoor in August 2004**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

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This is the report of an investigation into the circumstances surrounding the death of a man who was found hanging in his cell in HMP Dartmoor at 1.40pm on 23 August 2004.

The investigation was conducted under the terms of the transitional arrangements agreed between my office and the Prison Service, which came into effect on 1 April 2004. The bulk of the investigative work has been conducted on my behalf by a Senior Investigating Officer (SIO) from the Prison Service's South West Area Office. The SIO was assisted by an investigator from my office. An independent clinical review was conducted by the South Hams and West Devon Primary Care Trust. I am grateful to all members of the team for their work.

I have structured this report so that the SIO's investigation can be separately identified.

My investigator met the man's brother. I know my investigator has offered his sympathy and condolences, but I would like to take this opportunity to add my own condolences to the man's family and friends.

I should record here my thanks to the then governing Governor of Dartmoor, and her staff for the help the investigators received during the investigation. All staff co-operated fully and readily with the inquiry.

The man seems to have given staff and fellow prisoners no cause for believing he might make an attempt on his life when he did. However, it is also clear that he repeatedly sought a transfer to a prison in or close to London. Overcrowding pressures made this wish difficult, if not impossible, to achieve. Although I cannot know what was in the man's mind last August, it is difficult to avoid the conclusion that, had his wish for a transfer been met, he might still be alive today.

STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN

July 2005

SUMMARY

The man was born in October 1964. He had a troubled childhood and commenced offending from an early age. As an adult, he had many convictions, all for comparatively minor offences, and he served many periods in prison custody. The man was a user of heroin and crack cocaine and he reported that he committed many of his crimes to pay for his drug habit. The man was also taking prescribed Benzodiazepine.

He commenced his final period in prison custody on 3 May 2002. The man was initially received into HMP Liverpool as a remand prisoner, before being convicted in August 2002. He remained in Liverpool following his conviction and in February 2003, a self harm at risk form (F2052SH) was opened when he was found to have cut his arm. The wounds the man had inflicted on himself were superficial and, within a week, the F2052SH form was closed as he was no longer considered to be at risk.

The man was transferred to HMP Stafford in May 2003 and then spent some time in HMP Altcourse, before returning to Stafford. In February 2004, he was again subject to F2052SH procedures after he took an overdose of prescribed medication. On 24 March 2004, the man was transferred from Stafford to HMP Dartmoor. Depending on the outcome of parole applications, he had around two more years to serve in custody at the point he went to Dartmoor.

Almost from the moment that he was first convicted, the man began to apply for a transfer south. By south, he meant London, where two of his brothers lived. Following the death of his mother in August 2003, it was only from his brothers in London that he expected to receive social visits. When the man arrived at Dartmoor, he said that it was only when he reached Bristol that he discovered that he was going to Dartmoor, rather than to one of the London prisons.

The man seems to have had an unhappy time at Dartmoor. Staff who dealt with him, including the governing Governor all refer to what seems his overwhelming desire to obtain a transfer to London. At her interview for this investigation, the Governor said that she had many conversations with him about the difficulty in obtaining such a transfer. Beds were usually available at Dartmoor, whereas the London prisons were overcrowded. Even if a transfer was arranged, transporting a prisoner to a new prison was difficult due to the geographical isolation of Dartmoor, as it was not economically viable to transport a single prisoner. Staff suggested to the man that one option would be for him to move to a prison somewhat closer to London, such as Camp Hill on the Isle of Wight. From there, he would be more likely to obtain a transfer to a London prison than he would from Dartmoor. The man rejected this as an option.

The man was unhappy about the medication he was receiving. He had a hernia and complained about abdominal pain. This seems not to have

been directly linked to his hernia and which was being investigated. The man insisted that the analgesia he was being given was not controlling the pain and he asked for Codeine, an opiate, to be prescribed. Dartmoor has a protocol controlling the circumstances in which Codeine is prescribed. In his case, the doctors involved in his care did not feel that the pain as described justified the use of opiates. In addition, the man had a past history of opiate misuse so to prescribe Codeine would have been inappropriate in his case and circumstances. The Medical Officer at Dartmoor had many conversations with him to explain why he would not prescribe Codeine, but as in the case of conversations with staff about a transfer to London, the man seemed to find it difficult to accept or understand why he was being denied the medication he desired.

The man was seen by a mental health worker at Dartmoor at the end of April 2004. The mental health worker recorded that the man had a long history of self-harm and suicide attempts, cutting himself on several occasions and also taking drug overdoses. The mental health worker's opinion was that he had difficulty controlling his emotions, he appeared to have a poor coping mechanism, and his acts of self-harm were a response to social problems. This assessment by the mental health worker would appear to be borne out by events that occurred in June 2004 when the man jumped into the stair-well safety netting and threatened to jump from there to the ground. Three days after that, he deliberately cut himself. The man told staff that he was being bullied by other prisoners who were trying to take medication from him. However, he could not properly account to staff for dealing with that situation first by a threat, and then by an act, of deliberate self-harm.

The man's report of bullying was taken seriously, and two prisoners identified as being involved were dealt with under the prison's anti-bullying procedures. While this was happening, the man was located for his safety, and at his own request, in the segregation unit and an F2052SH was opened to monitor his mood and well-being. His segregation lasted only for a few days.

Prisoners at Dartmoor have the opportunity of joining the Amethyst group. This is aimed at prisoners having difficulty coping with prison life. To become fully engaged with the group, a prisoner would normally be expected to attend one-to-one sessions, and group sessions, and to agree a care plan. The man was invited to join the group, but did not wish to do so. Nevertheless, the Amethyst group leader was content for him to attend as and when he wished, and that is what he did.

Although staff described the man as a loner, he did have a number of friends at Dartmoor. He had been talking with some of his friends up to lunchtime on 23 August, and there had been nothing about his demeanour to suggest that he was at any risk that day.

All prisoners had been locked in their cells after collecting their lunchtime meals. At about 1.40pm staff began to unlock prisoners and, when the man's door was reached, the officer saw him hanging from a ligature tied to the window frame. Staff responded immediately, released him from the ligature and commenced attempts to resuscitate him using mouth to mouth and cardiopulmonary resuscitation (CPR). These attempts continued until the arrival of paramedics who suggested that attempts should cease, as he could not be saved.

I do not believe that the man's death could reasonably have been foreseen by staff at Dartmoor. He did not leave a suicide note and his friends had not noticed anything on 23 August to give them cause for concern. This assessment of him by his friends, accorded with the assessments of staff. Despite staff realising that the man was discontented with his situation, none thought that he was considering taking his life.

While not having a direct bearing on what happened on 23 August, examination of the man's records revealed some procedural deficiencies, such as a failure to carry out F2052SH reviews at the appropriate times. Some deficiencies in completion of paperwork were also identified, in particular record keeping in connection with the man's clinical records.

Recommendations have been made to deal with these issues and other recommendations have been made in connection with omissions identified by the clinical review. A more significant recommendation has been made for the Prison Service to consider its contract with escort services to assist in potential transfers out of Dartmoor.

The investigation team was extremely impressed by the Amethyst group, which this report cites as an example of best practice and which should be promoted across the prison estate.

SENIOR INVESTIGATING OFFICER'S REPORT

INTRODUCTION

This is the Prison and Probation Ombudsman's report into the tragic death of the man at HMP Dartmoor on 23 August 2004.

The investigation team would like to extend their sincere condolences to the man's family and friends.

The investigation team would also like to thank the Governor, staff and prisoners of HMP Dartmoor, for their hospitality, help and co-operation during this investigation.

In particular we would like to thank a Principal Officer who was the Liaison Officer at HMP Dartmoor.

INVESTIGATION PROCESS

The investigation team attended the establishment and met with the Governor and received a briefing of events and visited the scene.

The team examined all available documentation (relevant parts are contained within the annexes) and, from this, identified a list of staff and prisoners to be interviewed. Interviews with staff were recorded, whilst hand written notes were kept of prisoner interviews.

In addition to the formal interviews with staff, informal discussions were held with wing staff to obtain background information.

A clinical review was undertaken separately from this investigation although comments are made in this report from the medical record. The findings and recommendations of the clinical review are incorporated into the findings and recommendations of this report.

The core record and custodial documents file were examined and are included as appendices. Their content simply serves to confirm evidence gathered from other sources.

HMP DARTMOOR

HMP Dartmoor was built in 1809 and held French and American prisoners of war. It became a criminal prison from 1850.

Most of the buildings date from the late 19th Century but three wings have recently been fully refurbished. There is integral sanitation in all but one wing, and a new kitchen has been built.

Some wings are used for specialist reasons such as voluntary drug testing, vulnerable prisoners, induction and resettlement.

Dartmoor has a wide range of employment and resettlement opportunities for prisoners. Education is available full and part time, and ranges from basic educational skills to Open University courses.

Vocational training has been introduced and full time employment is available in catering, farms, gardens, laundry, textiles, Braille, contract services, furniture manufacturing and polishing. All these training opportunities are supported with NVQ or City & Guilds vocational qualifications.

There are offending behaviour courses including Enhanced Thinking Skills and Substance Misuse, supported by voluntary programmes such as the Alpha group and Alternative to Violence course.

Dartmoor has an operational capacity of 625 prisoners. On 23 August 2004, its role was 611.

THE MAN

The man was born in the North West of England in October 1964 and was single. He was the youngest child in a family of six boys, his father having died over 20 years ago.

At interview with a probation officer, the man reported that as a result of behavioural problems when he was aged 11, he had been placed in a Local Authority children's home. During his time in care, he became the victim of both physical and sexual abuse.

Since leaving school, the man reported having had many labouring jobs. He had a criminal record with 31 previous convictions and 60 offences. He had completed 18 prison sentences ranging from one month to 2½ years. The majority of the man's offences were of theft, which he reported to be often drugs related. He said that at the time of the offences leading up to his final period in custody, he was using Diazepam and heroin in addition to prescribed Benzodiazepine for epilepsy.

In August 2002, the man pleaded guilty to three counts of burglary at Liverpool Crown Court. He was sentenced to six years imprisonment.

RELEVANT EVENTS DURING THE MAN'S PERIOD IN CUSTODY

The man was remanded in custody into HMP Liverpool in May 2002. Upon being convicted, he initially remained in HMP Liverpool.

Within two weeks of being sentenced, the man submitted his first request for a transfer 'south' to be nearer to his family.

On 29 October 2002, the man again requested a transfer to London, where his brothers lived, so they would be able to visit. He received a reply on 6 November 2002 stating: *'I am able to advise you that the prison estate is overcrowded. Therefore ... a transfer out of area will be extremely difficult ... for the foreseeable future. You were sentenced by Liverpool CC and as a consequence it is likely that you will be transferred to a prison in the North West if and when spaces become available.'*

On 26 December 2002, the man barricaded himself in his cell and set fire to it. This was not treated as a suicide attempt, but his rationale for his actions was not recorded. If it was an action carried out to force a transfer it proved unsuccessful and, in fact, it resulted in him ultimately receiving an extra 18-month sentence for arson.

On 30 December 2002, the man applied for segregation for his own protection, which was approved.

A note of a conversation on 17 January 2003 recorded that the man had said that he had no intention of doing himself harm.

On 13 February 2003, a self harm at risk form (F2052SH) was opened following a member of staff answering a cell bell and discovering that the man had cut his left arm. The entry made in his medical record described the wound as 'a very minor scratch'. The man was reported as saying that he was: *'Fed up and wants transfer out of establishment. Stated does not want to take own life but just frustrated.'*

On 14 February, it was noted that: *'The man says he is very frustrated and would feel better if he could work in the laundry or do education. He says he would not harm himself again and is not suicidal, just angry.'* The F2052SH form was closed on 19 February.

On 9 April, the man's solicitor wrote to him explaining the efforts they were making to get him moved from HMP Liverpool saying: *'I do not understand your complaint that you have not been able to see me and that it is our fault that you have not been moved ... I have written to the Governor on a number of occasions'*

On 9 May, the man was transferred to HMP Stafford.

A form completed for induction at HMP Stafford gives the following responses:

<i>Do you use illegal drugs</i>	<i>No</i>
<i>Are your current offences drug related</i>	<i>No</i>
<i>Have you self harmed in the past</i>	<i>No</i>
<i>Do you want to stop offending</i>	<i>Yes</i>
<i>Do you think it is possible to stop offending?</i>	<i>No</i>

The stated aim of this form is to identify areas that can be addressed during sentence and help prepare for release. It could be argued that the disingenuous nature of the man's responses indicated his lack of willingness to engage what help might have been available. The author felt it poignant that the man agreed that he wanted to stop offending but did not think it was possible.

The man was seen by the Prison Chaplain on 12 May, who noted: *'Would prefer to be in [HMP Liverpool].'*

The Court of Appeal Criminal Division quashed the man's original six year sentence on 20 June and substituted it with a sentence of four years.

On 10 August, the man's mother died. It was recorded, unsurprisingly, that he was very upset at this news.

On 18 August, the man was transferred to HMP Altcourse.

On 4 September, the man lodged a formal complaint that the doctor at Altcourse would not give him cocodamol. He said that he had been receiving this drug for the previous three years following a road traffic accident. The man requested that he be either given this medication or that he be moved to another prison. The response from the prison stated: *'Any medication prescribed for you is appropriate for the condition you demonstrate. We do not support inappropriate prescribing practices in this prison.'*

On 19 September, the man was informed: *'A transfer back to Stafford prison is now being arranged, hopefully this will happen within the next 7 days.'*

At a Crown Court, the man was sentenced in October to 18 months imprisonment, consecutive to his current sentence, for setting fire to his cell in December 2002.

After his return to Stafford on 12 November, the man regained his job in the prison kitchen, which he lost on 24 January due to an altercation with another prisoner. He was given a job in one of the workshops but did not settle.

On 26 January 2004, a prison doctor wrote to the man's wing senior officer stating: *'He says he cannot work in workshop with lots of people. Is it possible to find him a job with a smaller group, subject to [earned privilege]. restrictions?'* The corresponding entry in the man's wing file says: *'Has seen doctor to get out of 8 shop due to his epileptic fits. He is swiftly making himself unemployable.'*

During a discussion with staff on 4 February about his work situation, an entry was made that the man had said that: *'He would not hurt himself but does not know how to cope.'*

On 8 February, an entry in the man's wing file states: *'Complaining of Hernia type medical problem – seen by duty nurse in Health care, seems a very inadequate individual.'*

On 10 February, an entry in the man's wing file says: *'Failed [voluntary drug testing] ... will be downgraded to [standard] not happy to be moved to A-Wing.'*

The next entry states: *'Found on his cell floor after unlock, Health care called to attend, Ambulance sent for. Inmate taken to outside hospital, possible overdose.'*

A F2052SH form was opened on 12 February. It states: *'Sent to outside hospital after overdose of prescribed medication. This was in response to being relocated from D-Wing back to main hall.'*

The nursing staff recorded: *'Does not want to go back to main hall and may be at risk of further s/harm if forced to move.'* The doctor noted: *'Today he denies any self harm ideation but I do not think that we can rely on his statement. He thinks that he will be allowed to go back on D-Wing – this is very unlikely.'*

Extracts from the 72-hour F2052SH review state: *'The man states that he feels better, but does not want to work in the workshops as he feels paranoid ... Wishes to transfer to London area so he can get visits from his brother.'*

The F2052SH was closed on 25 February after a review that noted: *'Appeared more positive than last review. His only concerns was that he wanted to be transferred and that he had written letter to Governor regarding this.'* In the support plan it states a member of staff will: *'... request update on transfer in 7 days.'*

A list of Sentence Plan targets set at HMP Stafford on 24 February identifies five targets, one of which states: *'To apply for a transfer to Southern region.'*

On 24 March, the man was transferred to Dartmoor.

On 29 March, the man was referred to the Amethyst unit (a support group) as he was identified as in need of support. He refused to engage with the process and his initial application was not completed.

On 1 April, the man again applied for a transfer to the London area. The response he received said: *'You have already sent a [transfer] application ... This will be answered in due course. At present with the large prison population moves are not as often as we would like.'*

On 4 April, the man submitted a formal complaint saying: *'I would like to know why I am at Dartmoor. I have been waiting to go to the London area for the past 2 years and was told by Stafford that I was going down South, it was only when I got to Bristol that I was told that I was coming here.'*

On 15 April, the man's wing file states: *'A very disgruntled young man given [an incentive and earned privileges] warning for smoking on the landing. He keeps demanding a transfer to the London area and will not listen to any information which is not in his favour.'*

29 April, the man submitted an application saying: *'I have been [by] mistake, sent to the Southwest instead of down South (London). I would like this sorted out ASAP, and sent to London for accumulated visits or allocated to a prison.'*

Also on 29 April, the man was seen by a mental health worker. Her report of the meeting included: *'... [The man] has a long history of polydrug abuse, mainly heroin and crack cocaine. ... he has a long history of [deliberate self-harm] and suicide attempts. He has cut himself on several occasions. He has also overdosed in the past ... There appears to be a behavioural pattern where he cuts himself, overdoses or becomes aggressive when social or prison problems occur, [e.g.] bullying. ... [the man] was pleasant on interview. He maintained good eye contact. He constantly fidgeted through the interview, moving from one foot to the other and wringing his hands. This appears to be a habitual behaviour rather than a symptom of anxiety. ... [the man] appears to have poor coping mechanisms, when confronted with a problem he tends to self-harm, to lash out, mainly at property. He appears to have difficulty controlling his emotions ...'*

On 25 May, the man completed a transfer application to the London area, which has been marked at the top Camp Hill, referring to the prison on the Isle of Wight. This was marked as approved by staff.

On 27 May, an entry in the man's wing file says: *'[The man] was removed from B1 landing by Seg[regation] staff after getting in demanding to see a Gov. This is all over a [transfer] which he is trying to get.'*

On 24 June, the man submitted a formal complaint saying: *'I believe the doctors here at HMP Dartmoor have acted in a negligent manner by knowingly leaving me in unnecessary pain by not providing adequate and useful pain relief.'*

On 29 June, a F2052SH form was opened. The initiating member of staff stated: *'[The man] claims that he is being bullied to hand over his medication. When told he was moving to A-Wing he jumped onto the netting on the 5's and twice stated he was going to jump.'*

On 30 June, a healthcare nurse interviewed the man about the events on 29 June and noted: *'Very anxious, has been bullied [for his] medication ... appears that his actions last night were impulsive. Could not give answer to his reasons.'*

The man's allegation of bullying was investigated, and while that was being carried out he was segregated under Rule 45 at his own request for a period of 72 hours. The investigation resulted in two prisoners being identified as bullies and dealt with under the anti-bullying procedures. An analysis of the available paperwork shows that the Segregation Safety Algorithm was started but not completed. However, this omission should be viewed in light of the fact that the segregation process, and the segregation under Prison Rule 45 paperwork, was initiated by the same junior operational manager.

An entry in the wing file of the man for 2 July says: *'He informed me that he was afraid because of bullying towards him on D-Wing. Multiple cuts found on left wrist.'* The cuts were referred to by healthcare as 'superficial'.

On 3 July, a case review was held, a summary of the review stating: *'[The man] cut his wrists last night but says he will not self-harm again. It has been arranged for his medication to be brought to the wing daily. He has several issues and is quite paranoid. I advised him to speak with staff if he has problems with other prisoners or if he feels he will self harm.'*

An extract from the man's wing file for 3 July, states: *'While escorting [the man] back to D-Wing he became aggressive and threw his bag at the window, located in B1 to cool down. Having watched this inmate over the past 24 hrs I am of the opinion that he is paranoid and totally unstable.'* The author notes that there is a requirement to hold a F2052SH case review after 72 hours, but in this case it was a day late. There is no evidence whether the incident of self-harm prompted the review or not.

A record of probation contacts shows on 8 July: *'Went to see [the man]. He is quite irrational and anti probation and prison staff. Claims to have been put on the wrong bus at Bristol prison – thought he was going to*

London – has been ‘requesting [transfer] to London prison for 2 yrs’ ... Spoke to [sentence management unit – the man] likely to go to Camphill shortly.’

When the author interrogated the records of the sentence management unit, the following was ascertained: On 23 May, a request was made by the man to be transferred to HMP The Mount. This was sent on 27 May, there is no evidence of any reply. On 1 July, a request was made by him, which was sent to HMP Camp Hill, on the same date. At an unknown date in the future, he declined this transfer.

The next F2052SH review was held on 12 July and noted: *‘Prisoner was very hard to communicate with throughout the review. He seems to think that everyone is against him. Not totally convinced that he will not self harm again in order to try to get what he wants. Although on a positive note he seems to be settled on D-Wing. Did not want to know about any agency of support as he stated he is paranoid and does not want any help.’*

An entry in the wing file of the man for 20 July states: *‘Has not eaten for a couple of days due he says to a Hernia which gives him an upset stomach. I have asked the kitchen to provide a soft diet, which he appeared happy with. He continues to be time consuming taking up a disproportionate amount of my time and has no concept that I have 28 other prisoners who require my time too. That said he does appear generally more relaxed and usually polite.’*

The next F2052SH review of the man on 20 July, stated: *‘It appears that [he] is not happy with his treatment, due to his medication being altered. He has an appointment to see the doctor tomorrow. He states he is frustrated about his treatment, transfer refusals ... when asked ‘about feelings of self harm’ states he still has feelings of self harm and didn’t appear positive about his current feelings. It is felt he should remain on this 2052SH until he is reviewed on [2 August].’*

On 9 August, the review said: *‘Good review. Prisoner seems in reasonable spirits and over the last couple of days he seems to be responding well to staff and his situation in general. Recommend closure.’* The author notes that this review was not carried out until 9 August – 20 days after the last review. Prison Service policy and HMP Dartmoor local policy state that after the 72hr review further reviews should be at intervals not longer than 14 days. Issues highlighted throughout this period on a F2052SH included being bullied for his medication, provision of a soft diet, being located flat due to his epilepsy, wanting cocodamol, and a transfer to HMP The Mount.

EVENTS LEADING UP TO THE MAN'S DEATH

The head of the Amethyst unit was asked about his work. He said: *'I run a unit called the Amethyst unit ... to support people who are having trouble with prison ... people who are self harming, people that are thought to be a suicide risk ... in other words really just people who aren't coping well with prison overall. We have had the rooms ... since before Christmas but I was running a unit actually on B5 landing for about three and a half, four years prior to us getting these rooms and changing our name to the Amethyst unit and having it as a day care set up.'*

Describing the man's involvement, the head of the Amethyst unit said: *'Well we thought he ought to come here, so we had him over to talk to him but he wouldn't fully engage and didn't want to come. So the sort of position we were left with was that if he needed to see us he knew we are here and you can come and talk to us but he wasn't fully engaged to come over and have one to one sessions or group sessions like we have. Very often he would, ... lose his temper a little bit and want to leave, any sort of challenge in any area he would want to leave so we never actually got to do a care plan for him ... we do a care plan where we go through a list of questions with the prisoner then we come to a sort of agreement and there's a [section] in the care plan and we say things that they need to do and things that we need to do and we sign up to that, they sign up ...'*

The head of the Amethyst unit also said: *'He had a point of view about everything, he couldn't be challenged on his points of view although they were flawed, he wouldn't deviate about it. I spent a couple of hours with him one weekend ... it was a very unusual conversation because he wanted to talk, but when things weren't going the way he wanted them to go, and you didn't agree with him, he would start walking away. He would get so far away and then he would have to come back again, it was most unusual behaviour.'*

The head of the Amethyst unit continued: *'... all of us ... tried ... talking to him, trying to get him to fully engage over here, trying to get him some support and for him to make slight changes, but ... you had no chance ... he just did not want to be here.'*

Asked about his most recent contact with the man, the head of the Amethyst unit said: *'On the Wednesday [actually the Friday] prior to his death he came with a mood on in the morning wanting to see me ... he had ... his parole papers and he said ... the [No. 1] Governor was dealing with his case personally and could I phone [her] ... I phoned [her] office which is quite unusual really because you don't normally get [the No. 1] Governor involved with a prisoner ... you maybe talk to an SO or governor on the wing ... But I thought he was quite agitated so I phoned the [No. 1] Governor, she wasn't in and I left a message with [her] secretary.'*

Asked his view if he thought the man to be a suicide risk, the head of the Amethyst unit replied: *'He never mentioned in any way, shape or form that he was considering ... he never said if I can't get out of here I am going to kill myself, or he never said, if I can't get out of here I am not going to wake up in the morning, he never said anything like that at all ... for the three staff that work here, it was a shock what he did, and it was unexpected. I know any death is a shock but nobody expected him to do what he did. We had no pre warning what he was going to do.'*

A member of the Amethyst group was interviewed about the man, he said: *'He used to come over [to the Amethyst unit], when he wanted he was here every day nearly ... He seemed to think it was all right, it did him a lot of good.'*

Asked about the man, the member replied: *'I have known [him] for 12 years, through the prison system ... When I came here he ... was on B-Wing and then D1 and he was on there, which I don't think he should have been put back in that situation, you know, because he wasn't really stable. I think they knew that but, I don't know, something about his tablets or something that is why he was moved off of B1 and went to D-Wing, boys were taking them off him. But he should have been put on 5 landing or something for mere support really, because he wasn't stable, you know, a couple of days leading up to his death he was all right, he didn't show any signs [of being] down or nothing like that, you know, he used to come out here and he seemed all right, he didn't seem as though there was a problem or anything, to me it was like he was under pressure, that is the way the guy looked to me ... But he never even mentioned it once, all he says to me was at bang up [at lunchtime on 23 August was] right I'll see you. He was waiting for a move out of here ... and he kept on telling them, and it wouldn't happen ... he should have been moved 'cos you know he was unstable, he was unstable to me, behaving as well but it didn't seem to be taken any further. He had support I know that, and ... he was building his hopes up, he was going back to his family so they can visit him. It wasn't happening, a couple of times it wasn't happening, but never mentioned it once that he was thinking of committing suicide.'*

The governing Governor was interviewed about her knowledge of the man. She said: *'He was an individual ... quite recognisable to me round the prison both because he was a member of the Amethyst Support Group and because he would talk to me on occasion on his Wing. What I knew about him in particular was that he came from the north-west and that he had family in London and that he was very keen to be able to be transferred to London ... He had believed that he was being transferred to London from Stafford and he could not understand why he had come to Dartmoor and that was really the main thrust of every conversation that I had with him ... his anxiety to be near his family because he was not being visited. I saw him most recently on Wednesday before he died which was the 18th of August. I remembered the date because in the course of our discussion he said he was feeling low because it was the anniversary of*

the funeral of his mother and it struck in my mind because it was also the anniversary of my father's funeral and we discussed the fact that anniversaries were difficult, but they got easier as time went on.'

The Governor added: 'We talked about the fact that he was not working, he explained to me that he suffered from severe epilepsy and was not able to work in the workshop environment and for that reason he did not have a job. We had him on the Amethyst Support Group because that counted as a job. It would be full-time activity if he wanted it to be and it would get him off the Wing and sort of mixing with people, whereas, I think on the Wing he was a reasonably isolated individual, he did not have a big circle of friends. I do not think he would have been described as a very popular man around the Wing. He, I think, was a bit older than most of the prisoners and was, I do not want to use exactly the word 'poor coper', but he clearly found being in prison difficult and he did not have the highest order of social skills to sort of help him sort of get through relationships with other people with ease. So I think he found being in prison quite a stressful experience and for that reason he was, he was on the Amethyst Support Group.'

Talking about the man's desire to move to London, the Governor explained: 'There was not a system that was going to actually deliver this for him. Both because we are not in the catchment area for London, because London is so overcrowded and it is always pushing people out north, south and west and because he is on paper at least appropriately allocated to a Cat C training prison and that there was not a reason for him to be allocated to a different Cat C training prison only for compassionate reasons. We talked about [HMP] The Mount; he told me that his brother was in Bethnal Green, so I thought ... north London ... I was not able to make him any promises, I said that ... it was not really something that was in my gift. I reminded him that there are hundreds of people here on any given day who are very keen to get nearer home because they do not get visited and it was something I was well aware of but could not necessarily help with. I did not promise that I would make any special arrangements for him. Then I began to form an opinion in my mind that he was somebody that I did want to try to help because I felt sorry for him and because I was aware that he was a pretty isolated individual who did not find things very easy. The other thing that happens [though] ... if we are moving people out of the area or to a prison that we do not normally send people to, you cannot get transport, it gets cancelled every week ... because it is not an economic route for the escort contractors to run ... So the only way that we could have been able to move him would have been for a personal Governor to Governor agreement. Which I could have done and then probably to have put a prisoner escort on. Which again in an individual case I can do but I can't make a habit of it because I am not resourced to do it and there are hundreds of other [prisoners with similar wishes]. I did feel he was unhappy, discontented but if I had ever felt an urgency about it I could have acted on that urgency.'

When asked about a move to HMP Camp Hill, the Governor said: *'Camp Hill [on the Isle of Wight] is an option that we sometimes use, sort of a backdoor to get people into London. Camp Hill like Dartmoor ... is a prison that is never quite full ... It is across water but it is a London prison ... we can get people placed in Camp Hill [but] whether we can ever [transport] them there is another issue. The whole population management thing has got little to do with where people want to be and very much to do with where there are beds and there are always beds here.'*

The Governor concluded her statement by saying: *'I don't feel very good about this because I do have a magic wand that I can choose to use for people and in hindsight how I wished I had waved it over his life. But ... if I had thought that he was suicidal or I had seen anything particularly urgent in his case then I might have done ... maybe if he had been in The Mount or Wayland or somewhere in shouting distance of London he would have found his problems actually were not solved by it, but that was what he was fixated on, that is what he wanted from us and I bitterly regret that we did not provide it for him.'*

Whilst accepting that with current population pressures all bed spaces are precious, the author feels that Dartmoor needs to have a clear regional role as part of the Category C estate. Prisoners should be sent there for a defined purpose – for offending behaviour courses, to gain qualifications, take up work or training opportunities, or participate in other resettlement initiatives – and the prison must be managed and resourced to provide those facilities. The author notes the work that has been undertaken to establish this regional role. Unfortunately, this may be undermined by the requirement due to the size of the prison population to transfer in prisoners from out of region simply because there are bed spaces at Dartmoor. The Governor described Dartmoor as 'the end of the line'. This may be accurate geographically, but certainly should be guarded against as a reason for allocating prisoners from the other end of the country. Whilst it remains unclear why the man was transferred to Dartmoor, it could be argued that it was not part of an integrated strategy for the dignified and decent treatment and resettlement of prisoners.

The Senior Officer took part in two of the man's F2052SH reviews, first on 12 July 2004 and then on 9 August 2004 when the F2052SH was closed. The senior Officer recalls: *'On the first review ... he wasn't interested in anything that was going on around him and he really didn't want to be there and as a group we were trying to talk with him rather than to him and his input was very minimal. He seemed more interested in getting back to his cell and having a cigarette or whatever it was at the time. That was one of the reasons ... we decided to keep him on the F2052SH. The second time that I ... did a review with him, he was a completely different person and on that occasion he was a bit more open, seemed to be more honest, seemed to be realistic about his future.'*

The Senior Officer also said: *'On the first review he was very blinkered insomuch as he really didn't want to have any input into the actual review, all he kept saying was, "I'm getting my transfer and I'm going back up to London. I've been trying to get there for three years" ... However on the second [review] he made no mention of transfers to my recollection ... he was a totally different person, he was very upbeat, he was quite openly engaged in conversation and he seemed very positive about his future.'*

When asked about the man's death, the Senior Officer said: *'... I was quite shocked. Probably more so because of the input I had had on the two 2052SH reviews and obviously like everything you start questioning: "Well did we do it right?" "Yes we did" "Did we ask the right questions?" "I think we did." I think ... we did ... everything we should have done.'*

An officer was interviewed as a regular D4 landing officer. Asked to describe the man, he said: *'He was troubled. His physical appearance although clean, tidy and physically well, he sometimes seemed nervous ... when he first came he would ... move from foot to foot on occasions, perhaps when he was more nervous than usual. After a while we built up more of a relationship and he would talk to me and other members of staff about problems that he had. Most of the problems as landing manager were the things that made up his day such as he would want to go to the hospital for a medical bath so I would have to organise that, take him across you know. And I'd try and help him out, for instance, when the other prisoners were locked up in the morning there's a cleaning routine and usually most prisoners are locked up so that [the cleaners] can clean the landings ... I'd usually leave [the man] unlocked.'*

The landing Officer also recalled: *'I don't know if he'd had an altercation with someone up there or there was a problem with that or perhaps it just made him nervous, but it was arranged that the medical staff would bring his medication to the wings ... Also his diet. He was a soft diet I believe, there were problems with that over a period of time and in the end ... I phoned the kitchen and organised that, I think there were a few errors with that initially and then he seemed to settle down and he seemed happy with it.'*

Asked about the Amethyst group, the landing Officer said: *'He ... went as and when he wanted ... He sort of dropped in and dropped out ... he would come up to me and ask ... it seemed to calm him you know, I would say yeah that's fine, Ill ring up and if they'll have you then I'm happy for you to go up there.'*

The landing Officer was asked to describe any change in the man during the period he was on a Self harm at Risk form: *'When he arrived on the landing ... he was quite nervous, down but he never really ... withdrew as such. You know, he would still talk, often when people are depressed they sort of tend to withdraw into their cell and you don't see them for days but he wasn't like that and as I got to know him, and as I did the things*

that I've told you and that seemed to make up most of our working day together, sorting things out, walking up to Healthcare etc. and as that went on, his state when he first arrived appeared to improve and he seemed to become more talkative, a little bit more upbeat ... He stopped that shuffling movement that I was talking about earlier, it didn't seem to be as pronounced or as often. I believe sometimes he used to stutter and that seemed to become less frequent and also he spent a lot of time in a prisoner's cell and talking to other prisoners and he seemed to relax a lot more and he appeared to be a lot happier.'

When asked whether he felt that the man would get upset over trivial matters, the landing Officer responded: *'I would say that he was the sort that ... didn't cope well with perhaps things being out of sync with the way that he slowly built up his day ... I would say he would react more to things going wrong than perhaps most people.'*

Asked if he felt the man was a potential suicide risk, the landing Officer said: *'I definitely thought, when he arrived, that I needed to watch him carefully and that's what I did and he appeared to improve in my eyes and obviously to other people because they took him off the [F2052SH] in the end.'*

When asked about her knowledge of the man, the Staff Nurse replied: *'... he was quite a regular customer to us, he used to come to ask for his medication, to sort of like chat ... He was quite a quiet man. He used to complain a lot about lots of things but it was like small complaints ... trivial things ... I think was quite a weak person, a weak personality and I think he would be the sort that would have been easily bullied and things like that. I think he was quite a vulnerable person.'*

The Staff Nurse was asked specifically if the man appeared overtly depressed or suicidal. She replied: *'No.'*

The D-Wing Senior Officer (SO) described the man, saying: *'He was quite fixed in some of his ways. Sometimes he wasn't a very sort of happy chap. He was quite fixed in that he was trying to get out of Dartmoor for the transfer request; those were going through the normal process. Quite often he would sort of pull staff moaning about something that wasn't to his liking and yet the next minute he could be having a laugh and a joke with the staff ... I wouldn't say up and down, but one minute you think, "oh he's not very happy, he's disgruntled about something", and then the next minute he'd be having a laugh and joke with staff about things.'*

Regarding the man's transfer requests, the D-Wing SO said: *'He wanted to get back to the London area and I mean some of the prisons he was asking for, there was no way he'd go there, local prisons or places like Belmarsh, we even suggested names of places that he could put down for, but we said to him if one place doesn't accept you, you can always apply*

for another ... If somebody suggested Camp Hill to him it can only be to move to the South East region or as close to it as possible.'

The duty governor on 23 August 2004, said: *'the man had been at Dartmoor for quite a considerable amount of time. He was a prisoner, I didn't think really wanted to be at Dartmoor. He was transferred I believe from a northern region. He was a prisoner that had, shall we say, coping difficulties in prison. He had at one time been part of the Amethyst ... support group ... We arranged a transfer for him to Camp Hill which he then turned down ... he said he ... just wanted to be in London and we explained to him because of a lot of pressures in London it was very, very unlikely that he'd get directly from Dartmoor to London and that Camp Hill would be a good stepping stone because it was in that direction.'*

The duty governor closed by saying: *'I just think it's sad, I think it might be an accident, whether he meant to do it I'm not sure, but ... he was quite fiery, he would just sometimes react inappropriately but he wasn't someone that I would say was actively suicidal.'*

The Medical Officer for Dartmoor, gave a statement to the police where he stated:

'This man was ... seen by my colleague on 25 March on reception [at Dartmoor]. She noted that ... he had a reducible left inguinal hernia so she referred him to the visiting surgeon ... Her concerns were that he presented, "as extremely slow and unable to give a really good account of himself" ...

'He saw my colleague again on 27 April who commented that he appeared to be, 'more switched on', that day. He requested Codeine for the pain and it was explained to him by my colleague that it was not indicated. ...

'He was seen by a member of the In-reach Team on 29 April who did not feel that there was any evidence of psychosis, depression or anxiety but that there was a history of self-harm and suicide attempts which "predominantly occur when environmental factors affect him, i.e. bullying, negative [mandatory drug tests], social factors". ... [A] review was done on 19 May and it was decided that there should be no further input from the In-reach Team as there appeared to be good interaction during the interview and there was no evidence of any suicidal ideation and he denied any intent.

'... he had several contacts with either myself or medical colleagues in Health Care where his complaint was of pain in his left groin. Without exception, all the doctors felt that the pain described was inappropriate to the clinical condition, i.e. the hernia. The opinion was that he was trying to obtain opiates, and because he had a past history of opiate misuse, that [to give Codeine] would be

inappropriate prescribing. It would be inappropriate for somebody who appeared to be suffering from chronic pain, which had no appropriate explanation, and we also have a non-opiate prescribing policy unless it is indicated for acute pain or in chronic pain where the diagnosis has been appropriately established and that treatment recommended by a specialist department ...

'During my last consultation with the man he again insisted that he was in a great deal of pain ... I again repeated my reasons for not prescribing [Codeine] ... Although he said he couldn't stand the pain, he gave no indication that he was going to self-harm or make an attempt to take his own life ...

'Throughout his time at Dartmoor he made numerous complaints, both through the complaints system internally and to the Area Manager about what he perceived to be denial of correct analgesic medication.'

In his interview for this investigation, the Medical Officer said the man: *'Always seemed [a] very anxious person, it was fair to say that he was not happy with the medical intervention that he was getting, he felt that he should be getting stronger pain killers for the pain he kept on describing, and as I explained to him on numerous occasions I did not feel that opiates, which is what he wanted, were appropriate ... it was inappropriate for him to have opiates like Codeine or whatever for chronic pain which we weren't sure about and somebody who unfortunately had had a history of substance misuse in the past.'*

The Medical Officer stated: *'I had seen him, I think it was on the Friday before he died ... I said to him, "It would still be the painkillers I would give you for that would still be the ones that I have given you all along", and I think, to be fair to him, I think he made some comment that he just couldn't stand the pain but he certainly didn't give any indication that he was actually going to take his life because of the pain. He would sometimes laugh it off but I got the impression from him that it was as if he would try something but he knew that if he was blocked well that was the situation, but he was going to try it the next time ... he didn't shout, I don't think I ever had a shouting match with him as I do with some customers who are very unhappy, I mean he said he was unhappy but that was it, he just said okay and that is it.'*

The Medical Officer observed: *'I just felt that when I was trying to explain the background of pain and why I was concerned about the opiates, normally people will give as good as they get, they will, particularly if they've had a substance misuse problem and often be better read than I am about the side effects and things. [But with the man], he would just look at me and then say, well I need the opiates, so it was like a stuck record almost and I, it just felt to me that either he wasn't prepared to listen which is a possibility, or that he just didn't have the intellectual*

capacity to make that jump, to him it was I need pain killers, I have got pain, I found something that was helpful, I want it ... the fact that I was saying it might be dangerous for him just, well I want it, I must have it and that is, if you like an intellectual leap that some people can't make.'

A fellow prisoner, said that he was a very good friend of the man, having known him for five to seven years through serving time together at Channings Wood and elsewhere. To this prisoner, the man had seemed a bit more depressed during this sentence than had previously seemed the case. The prisoner said the man was quiet and down to earth, a person who kept himself to himself. The prisoner had told the man to speak to him if he had any problems. The prisoner had lent the man £40, which he was having trouble in repaying, but the prisoner was in no rush for return of the money and had not put any pressure on him for repayment.

A second prisoner, said that he was not a close friend of the man, but they did speak now and again. The second prisoner said that the man had wanted to go to London and had believed that he was going to London when he was transferred out of Stafford. The second prisoner said that the man had said that he was going to hit a Governor to get his transfer. However, the second prisoner told the man that he had been in Dartmoor for three years and that it was a difficult prison to get out from. The second prisoner said that he did not think that the man had meant to kill himself, he thought instead that it was either a cry for help or an attempt to force the prison to move him out.

A third prisoner, said that he had known the man for six weeks. He said that the man had had a 'bad' telephone conversation and he wasn't surprised that the man had taken his life. The third prisoner said that the prison could have transferred the man close to his family in London, but instead he had been kept in Dartmoor.

The author notes that the third prisoner was not very co-operative and it took more effort than normal to get his contribution. There is no other contributor that substantiates the third prisoner's assertion that the man was kept at Dartmoor when he could have been transferred to London. The weight of evidence demonstrates this assertion is not sustainable.

Establishments across the estate now utilise a system where prisoners apply for access to a limited number of telephone numbers (e.g. family, friends, solicitor etc.). They are issued a Pin Number, which unlocks the phone system only to allow access to their pre-authorised numbers. This is known as the PinPhone System. A record of the man's account details is enclosed as Appendix 38. It records his last call as occurring on 4 August, lasting 14 minutes 16 seconds. As calls are recorded, a transcript of this call is enclosed as Appendix 59.

The man made this call to his brother but he was not at home so initially the man spoke to his sister-in-law. He said: *'They have had me down the fucking block and all that, I have smashed me fucking radio and the*

fucking telly right, I had a barney with some screw in the fucking pad, he won't have me down the block right, they threw me off the fucking block. They put me on fucking D wing here where I am now.'

The man went on: 'I have been trying to get fucking down to London. I only done eight months on remand, do you know what I mean, so it is like takes two fucking just on two years right, I have been putting my application in, application after application, right for transfer to London in to The Mount which is in Hemel Hempstead or fucking Highdown or somewhere like that, do you know what I mean is in Surrey where I was last time and our Robbie come and visit me. Fucking you know they say they sent the files off and all that, right and they are just waiting for an answer.'

When asked how long he had to serve, the man said: 'January 2006 I got about 16 months left. No problem do you know what I mean I can do that on me fucking head you know the score.'

The man went on: 'I have got to get out of here, this governor here right, is fucking me about do you know what I mean, he is saying, listen you are on the first right shift out, do you know what I mean, I have told him straight there is people going to the Isle of Wight, you know the Island where I was last time in Camp Hill, see what it is right, my file right, no fucking jail will accept me.'

The man then said: 'I am waiting for this governor to come back on, he is back on next week, do you know what I mean, and I will get shift out, because I am going to fucking bang him right on the fucking chin.'

When the man's brother arrived home and came onto the phone he asked his brother if he was still in the same place. The man said: 'Yea, I am still, right, I have been trying to get me right over to the Isle of Wight, I ain't fucking going, I have told them straight.'

The man told his brother: 'I put in for a transfer right to London, do you know what I mean, and it is like nearly fucking two years, you know what I mean trying to get to fucking London. Well on the outskirts, Hemel Hempstead or may be like fucking you know that place where I was in High Down where you used to come visit me ... well there is one next to it called Down View, that one.'

The man also said: 'They have got to send me to a fucking a Cat C jail somewhere, and no one, they are sending me files to different jails right, and they are saying, 'no we don't want him', because my file's fucking bad news you know what I mean. They won't accept me; it looks like I am fucking stuck here for the time being like. I have been down the fucking block and everything, and they won't even have me down the block now, they won't even nick me, do you know what I mean, because I just, I can't even go off the Wing right, I can't even leave the Wing, I have to get

my, the screw brings my medication over and all that right, every single day, you know what I mean. If I go off the Wing I have got to go to the hospital for an appointment, a screw has to take me fucking over.'

The man stated that he was willing to pay for his transfer saying: *'They are saying that it is not easy as that, they are just fucking just winding me up do you know what I mean, fuck them anyway.'*

The man, talking about how long he had left to serve, said: *'You know if I wouldn't have got that 18 months consec right, I would have been out right, and about two months, 'cos you do two years eight months out of four years, do you know what I mean, but what they don't right they calculate the fucking the four years and the eighteen months and you put it together and the Judge saying now that I have got to do the four years and then start the eighteen months, so next month right I will have done the four years right.'*

The man closed the call by saying: *'I'll get off. I will phone you up, I don't know maybe the weekend or something like that, all right, I'll see you later mate. All right, see you love, bye.'*

The investigation team reviewed the man's sentence management file. His DCR 2 review dated 10 June 2004, demonstrates that he had met his target to apply for a move to a prison in the southern region, but had not met his target to contact CARATs.

His DCR 2 review states that the man was not fully aware of the sentence planning process and had refused to sign the form.

A risk assessment to move the man to a prison of lower security category (from Cat C to Cat D) was carried out on 2 June 2004. The man was described as, *'very argumentative'*, and, *'Abuse of trust high'*. Under significant issues it is recorded: *'Drugs (substance abuse noted as medium), general attitude poor can and does become very aggressive, control problem noted as (medium) needs supervision, unstable person.'*

The result of the risk assessment was that he was to remain as a Cat C prisoner.

THE MORNING OF THE MAN'S DEATH

The D-Wing SO said: *'On Monday 23 August 2004, I was working on D wing, carrying out the duties of D wing Senior Officer ... during this time I had spoken with [the man] on several occasions, but each time it was regarding everyday matters and he had at no time discussed or stated any intention of self harm, or of having any suicidal thoughts. At the time the lunch meal was being served, [the man] came to the servery on D2 landing, but decided he didn't wish to take a meal. The selection he had ordered was a soft diet and it had not been delivered. When he was informed that one would be collected for he stated, 'Don't worry' and he returned to his cell D4/17.'*

The D-Wing SO stated: *'Throughout the morning there was no time really where he showed any signs that he had any thoughts of self harm or suicidal tendencies. I had no areas of concern about his behaviour that morning.'*

The head of the Amethyst unit said: *'On the day he died he came up again on the morning, and he said more or less the same thing [for the officer to phone the No1 Governor about his parole papers because she was dealing personally with it] and the No 1 Governor had not got back to me. So I phoned the Governor's office and got no answer whatsoever, there was nobody in, the Governor's Secretary wasn't there either. So he then said that he wanted to go back to the wing and talk to the SO. So I ... phoned the Wing to let his landing manager know where he was because he told me that he hadn't told anybody that he had left ... I got a movement check for him and sent him back to the Wing.'*

The head of the Amethyst unit also said: *'He had his parole papers, and he was concerned that if he started his parole papers he would stay here. But the Governor was involved trying to get him a move, and that if he signed his parole papers he would have to stay here to have his parole done. He was in a sort of quandary really. That is when I sent him back to the Wing when he said, 'if I can't get the Governor I will go and talk to the SO on the Wing'.*

The first Officer said: *'[The man] came to me and said that he had got a problem ... he had got parole papers and will it affect his transfer, and I said as far as I know if you have got parole papers it blocks it for six months.'*

The first Officer recalled: *'... I got a phone call from an officer [from the B5 Amethyst support group] asking for [the man]. I said, 'he is in his cell I will go and get him', 'No, no' he said, 'he is up here with me', so I said, 'How did he get up there?', and he said, 'well he just walked up there, he just come up here.' So I wasn't aware that he had gone up there but that is fine and he mentioned again this thing about parole and could he see*

the SO on the wing and I said, 'Yes, he is here send him back when you want.'"

The first Officer said: *'Two officers said they had to go off to adjudication and gave me the radio so I was on the 2's landing for the rest of the morning instead of the 4's. At twenty past twelve [in fact twenty past eleven] they hadn't come back so I had to go and get the meals, came back about half past twelve [eleven] with the meal and then returned to the 4's landing and on my way upstairs the man spoke to me and said, 'Could you unlock me to go to B5 at half past one this afternoon,' and I said, 'No problem.'*

The first Officer stated: *'I went down the landing checking everyone had gone, [the man] had already banged up, he was the first one to bang up, I asked him if he had got his meal and he said no they hadn't sent it over, I said, 'I will go and get it', but he said, 'No, it's all right gov it's fine I don't want it.' So I banged up the rest of the landing, did the roll check, came back and checked him and he was sat on his chair, he had something at the side of the bed, either a tin or biscuits or sweets or something so I assume he was happy he had something to eat anyway.'*

The author notes that two letters were posted out from prisoners after the incident discussing the man. One was from a prisoner who was interviewed, the other an extract from an unknown prisoner.

The prisoner who was interviewed observes in his letter: *'I found my mate dead in his cell, he hung himself during the dinner hour, it's really done my head in, I feel like crying but I can't, I just feel numb. Things like that you don't expect to happen, but when it does, it knocks you for six. I was talking to him dinnertime before we banged up, he was OK, but when they reopened us he was dead, hanging from the bars. Only he knows why he done it, that's a secret nobody will ever know about.'*

The extract from a letter of an unknown prisoner states: *'We got banged up at dinner time and me little scouser mate hung himself. He was okay this morning, me, him, and two prisoners were all sitting in my cell and he seemed fine so fuck knows what happened there.'*

Another prisoner recalled that on the day the man took his life, he and the man had been together from 10.30am to 11.45am. They were drinking coffee and chatting, and the man had said nothing to indicate that he was depressed or having thoughts of self-harm.

The Governor recalls: *'I spent the morning, the whole morning doing the adjudications down in B1 and while I was in B1 I now know that an officer was again trying to get hold of me because he had had a session with the man, who wanted to ask me for advice about parole. That was the first I was aware that he had an issue about parole.'*

When asked why parole would effect a transfer, the Governor said: *'If you transfer while the parole reports are supposed to ... be written ... you are placing yourself into a prison that does not know [you] and therefore is not in a position to recommend ... So generally people are not transferred during the parole window. They can be, but from their point of view there is a decision that needs to be made ... it is probably not the best idea in the world to be taking a transfer out of area just at the moment when your parole report should be written so it is not a question of policy, it is ... about weighing up your priorities.'*

THE MAN' S DEATH

The first Officer said: *'[There were] no problems over dinner ... no bells ringing, no noise, no disturbances or anything ... At 1.40pm ... I was unlocking D4 landing to go to work. When I got to cell D4.17, occupied by [the man], I opened the flap and saw his TV and locker out of place in the middle of the cell. I then saw [the man] hanging by a green material from the window ... I leaned over the landing, called [the second Officer] who was on the 3's, he came up, we went in the cell ... I lifted [the man] up [the second Officer] undid the knots and as the second one came undone ... as the weight increased, [the man's] arms just shot up in the air and [he] slipped out, he [fell] into the corner of the room ... [we] put him on the bed, there had been no alarm raised by that time because we were trying to get him down ... I went out on to the landing and there was an inmate passing ... and I told him to ring the alarm bell, so he did that, as I turned round and went back in [the third Officer] from 5's, has come down and was actually giving him chest massage.'*

The third Officer stated: *'I had reached D5-23 when [a prisoner] called me from the D4 landing that the officer needed assistance urgently, an inmate was hanging ... With the man on the bed we proceeded with resuscitation.'*

The D-Wing SO described his actions on hearing the alarm: *'I came up the stairs and instructed staff to put everyone away at that time, stop the movement which the staff started to do and we got assistance from other areas of the prison. As I got to the 4's landing, the first Officer was outside D4.17 ... it wasn't till I got to the cell I found the other staff there and that was [the second and third Officers] who were in the cell and they were carrying out CPR on [the man] ... I [remained] ... immediately outside of D4.17. I was ensuring there were no unauthorised personnel entering the cell.'*

The Principal Officer (PO) said: *'I went into the cell, [the man] was lying on the bed face up ... [the third Officer] was just about to start chest compressions. He ... said ... that [the man had] been found hanging, he'd moved him to the bed and I started mouth to mouth and the [third Officer] started chest compressions ... another officer took over [the third Officer] ... We did that for approximately ... ten minutes while the Healthcare staff got there.'*

The Staff Nurse said: *'Myself and another nurse ... arrived ... we found [the man] on the bed ... the PO was giving mouth to mouth resuscitation and I believe ...another officer ... was giving CPR ... I could see that [the man] was looking blue, that he had no radial pulse, he had no carotid pulse and that his pupils were fixed and dilated. I took over the airway from the PO and the other nurse brought in the heart start machine, which ... we can use to defibrillate ... this showed there was no response at all. We carried on with resuscitation until the co-responders (the fire*

service) ... and are trained in paramedic techniques arrived. This must have been maybe ten, twenty minutes.'

The duty governor said: 'The local fire brigade ... brought the defib machine to the scene. I believe they could not get a response to actually shock [the man] and their ... indication to me ... was that he was a pretty much a hopeless cause, however they did the best they could and continued to try to give mouth to mouth or CPR ... until the arrival of paramedics. Once the paramedics arrived, they quickly indicated that ... it would be pointless carrying on with CPR and they pronounced that CPR should stop. We then waited for the police and [Medical Officer] to attend. The [Medical Officer] attended the prisoner and pronounced him dead.'

The Log-keeper's Log, used to record all events reported to the Control room, is reproduced below:

13.47	Urgent message from an Officer
13.49	Ambulance requested
13.50	Ambulance called
13.52	Police called
13.55	Fire brigade arrives
14.02	CID en-route
14.10	Ambulance arrives
14.12	Paramedics on Delta wing
14.15	Medical Officer called
14.15	Pronounced dead by paramedics
14.16	Medical Officer paged
14.20	Chaplain requested
14.20	Police liaison officer contacted
14.25	Chaplain on Delta wing
14.25	IMB contacted
14.27	NOU contacted
14.45	Samaritans contacted
14.56	The Medical Officer called
15.00	Samaritans call back
15.02	Police contacted again
15.05	NOU updated
15.16	The Medical Officer arrives
15.27	3 Police arrive
15.29	The Medical Officer on delta wing
15.30	Confirmed dead by the Medical Officer

AFTER THE MAN'S DEATH

The D-Wing SO states: *'I returned to D2 landing at this point and was involved in ensuring all tasks were completed as normally as practically possible. I then took part in interviewing some prisoners who had been identified as possibly being at risk after this tragic incident.'*

The care team co-ordinator, attended D wing and spoke to all staff involved. That evening he contacted the three officers who had been sent home.

The PO said: *'[The first and second Officers] especially, they were quite upset by the whole event... it affected them quite badly, but they did see staff welfare before they left the prison. [The third officer] ... was [also] quite shaken up. Again he [saw] ... staff welfare before he left ... I ... thought ... they could have give some input [at the hot debrief] but we know what they'd done anyway.'*

Dartmoor contacted HMP Chelmsford and asked for staff from that prison to visit the man's brother to break the news of his death in person. The deputy governor and a chaplain visited for this purpose. The governing Governor subsequently spoke by telephone to the man's brother and the duty governor spoke to both the man's other brother and to a sister-in-law of the man's living in Liverpool.

The duty governor said: *'We also called the Samaritans who then attended the prison and actually spoke to prisoners. I managed to speak to wing staff to find out who the man's best friend was and we went and saw him. He was very, very shocked when I broke the news to him. He'd been speaking to the man that morning and ... he'd ... given no indication that [he] was going to do this. He was very shocked. I asked a doctor who was there to go and see him ... [the] chaplain and Samaritans [also] saw him ... the chaplain [said] the last rites in the cell ... [for] the man ...'*

The duty governor stated: *'The deputy governor attended the scene and he did a hot debrief with myself, the PO, the SO ... and there were some of the wing staff and we discussed what needed to be done, had everybody been seen, the care team were there, they attended and we spoke about anybody that particularly we had concerns about.'*

Subsequently, the investigation team reviewed Dartmoor's Suicide Prevention Policy, its Anti-Bullying Strategy and its Incentives and Earned Privileges Scheme. All these documents demonstrate that Dartmoor has a comprehensive and robust system of policies to apply HM Prison Service Standards.

FINDINGS

On 9 August 2002, the man was sentenced to six years imprisonment. Within a fortnight of being sentenced, he requested a transfer south. He consistently applied for a transfer to the London area throughout his time in custody.

On 13 February 2003, the man became subject to a self harm at risk form (F2052SH) following a member of staff discovering that he had cut his left arm.

On 20 June 2003, the Court of Appeal quashed the man's six year sentence and substituted a sentence of four years. On 15 October 2003, the man was sentenced to 18 months imprisonment for setting fire to his cell in the previous December. The 18 months sentence was consecutive to his current sentence.

On 10 August 2003, the man's mother died.

On 12 February 2004, the man became subject to a F2052SH form after a suspected overdose of prescribed medication.

When the man transferred from HMP Stafford to Dartmoor on 24 March 2004 he claimed he had been told he was going to London. He was offered a move to HMP Camp Hill on the Isle of Wight, from which a transfer to London would have been easier. The man refused to move to Camp Hill as he was determined only to move to London.

Dartmoor often has cell spaces and receives prisoners from around the prison estate who then want an onward transfer, which Dartmoor is often unable to achieve.

On 29 March 2004, the man was referred to the Amethyst unit as he was identified in need of support. He did not become a full member of the group, but he regularly dropped in.

On 23 May 2004, the man requested a transfer to HMP The Mount. There is no evidence that he received a reply to this request.

On 24 June 2004, the man submitted a formal complaint about his medical treatment, specifically inadequate pain relief. He had made a similar complaint in 2003 when he was at Altcourse. The Medical Officer explained to him why it would be inappropriate to prescribe him opiates.

On 29 June 2004, the man became subject to a F2052SH form reporting he was being bullied and after threatening to jump from the landing netting. The allegation of bullying was investigated utilising Dartmoor's anti-bullying protocol. Two prisoners were identified and dealt with under the procedure.

On 2 July 2004, while still subject to F2052SH procedures, the man cut his left wrist.

While subject to F2052SH procedures in the period 29 June to 9 August 2004, reviews were not carried out within the intervals specified in Dartmoor's Suicide Prevention Policy.

On 20 July 2004, the man was noted to report that he had not eaten for a couple of days due to an upset stomach caused by his hernia. Staff arranged for the kitchen to provide a soft diet, but this was not consistently provided.

The man was variously described as having coping difficulties in prison, showing anxiety.

On 4 August 2004, during his last recorded phone call, the man told his sister-in-law that he about 16 months of his sentence to serve and that he would have no problem serving that amount of time.

During the week before his death, the man asked staff about what effect signing his parole papers would have on a potential transfer. He was advised that involvement in the parole system could impede his transfer.

At 1.40pm on 23 August 2004, the man was found hanging in his cell. Staff untied the noose, laid him on his bed and attempted to resuscitate him. The attempts were unsuccessful and the man was pronounced dead by the Medical Officer.

All prisoners and members of staff interviewed expressed their surprise at the tragic events of 23 August 2004. The man was not subject to F2052SH procedures at the time of his death. He did not leave a suicide note.

Staff saw prisoners who had been identified as at risk after the incident, including the man's friends.

A hot debrief was conducted with available staff, however the three staff first on scene had already been sent home. Although the decision to send them home was taken in view of their welfare, their best interest might have been better served by being involved in the debrief, rather than through having to deal with their feelings, possibly unsupported, at home. All staff involved with the incident were seen by the prison care team.

Dartmoor arranged for the man's family to be told of his death through a personal visit from staff from HMP Chelmsford.

FINDINGS OF CLINICAL REVIEW

The review found that the man's pain control management and care-plan programme were appropriate. However, the care plan was not obvious as it was not specifically written down.

The review found that the recording of clinical notes was not generally satisfactory. Some entries were not clearly legible, and sometimes the author, professional status, and title of the maker of an entry was omitted resulting in uncertainty for the reviewers of the author's professional status.

It was agreed that the introduction of a computerised health record at Dartmoor would benefit new clients, but not existing clients whose historical records will remain in manuscript format.

The lack of cross-referencing in paperwork notes was identified as being problematic. Specifically, forms such as the F2052SH, which can be initiated by any member of prison staff, may not always be recorded in the healthcare record. Similarly, it is not always recorded on the healthcare record that a self-injury form had been completed. Also due to confidentiality, participation programmes such as the CARATS programmes or attending self-help support groups is not always recorded in healthcare records.

The clinical review team remarked on the fundamental difference in the 'significant event process' as undertaken by the PCT and by the prison. This was considered evident not only in the actual process but also in relation to the underlying philosophy of a review which, in Primary Care, is very much a non-blame culture and one of learning and sharing outcomes.

CONCLUSIONS

The man was a 39 year-old man experienced in prison life, with many previous convictions and terms of imprisonment, mostly relating to offences of dishonesty or related to his drug abuse.

The man self-harmed by cutting his wrist and by taking an overdose. He also set fire to his cell and threatened to jump off a landing. There is also evidence that at times the man was being bullied for his medication. The man subsequently denied suicidal ideation, however, and this may suggest a pattern of behaviour on his part designed to achieve other aims than of serious harm to himself.

Dartmoor is a geographically isolated prison and the man was one of many prisoners unhappy to have been located there.

The man tried for two years to get a transfer to a London prison, as he believed that this would enable his family to visit him, and he also wished to settle there on release. His inability to achieve the transfer he desired caused him great frustration and was the driving force behind many of his actions. He seems to have failed to understand the efforts being made to get him the transfer he desired.

The man complained for many months of a pain that was being investigated by healthcare staff, but for which various doctors would not prescribe opiate based painkillers. The doctors failed to convince him of the inappropriateness of prescribing opiate based medication to a former opiate addict. It seems that the man felt that prison doctors were not treating him correctly.

The man variously refused help from CARATs, denied he had drug problems, and refused to engage fully with the Amethyst unit at Dartmoor. His poor coping skills coupled with his rejection of available help may have exacerbated the stresses he felt. It is unclear whether the man intended to take his life or whether his actions were intended to be a cry for help. There were no indications to staff or prisoners that the man was suicidal that day. He had appeared as normal during the morning.

RECOMMENDATIONS FOR HMP DARTMOOR

1. Staff involved in the processing of transfer requests should maintain clear and comprehensive records, providing prisoners with written confirmation of how their cases are progressing.
2. F2052SH reviews should be carried out at the correct time intervals in accordance with policies and procedures.
3. A hot debrief was held without the three staff first on scene, who had been sent home. A system should be implemented to ensure that all involved staff are able to attend debriefs, if that is what they would prefer to do.
4. Segregation Safety Algorithms must be fully and correctly completed.
5. Staff should be reminded that, when attempting resuscitation, the patient should be placed on a hard, rather than a soft, surface.

RECOMMENDATIONS OF THE CLINICAL REVIEW

6. All clinical records should be legible, contemporaneous, clearly dated and in chronological order. Staff should indicate their professional status or title, and append their name legibly.
7. A medical summary card should be attached to the front of the healthcare notes. Additional forms completed such as an F2052SH and/or F213 should always be noted within the healthcare records. It would also be useful, where it is known that individuals are participating in structured programmes such as the CARATs programme or self-help support groups, this should also be recorded in healthcare notes.
8. Any medical examination of individuals and/or agreed care-plan for individuals should be clearly recorded within the healthcare notes.
9. The Prison should invite the PCT to significant event reviews. This will allow for joint learning and potentially joint training opportunities.
10. A clearly defined process for undertaking significant event reviews, including deaths in custody, should be developed and agreed locally between the prison and PCT. This would ensure a more timely response and greater clarity in terms of roles and functions.

RECOMMENDATIONS FOR THE PRISON SERVICE

The Prison Service should re-examine its contract with escort services to ensure that all transfer requests from whatever location are dealt with equitably.

GOOD PRACTICE

The investigation team felt that the Amethyst unit was an example of good practice.

The Amethyst unit was found to meet its stated aim of providing a safe, caring and protective environment where prisoners can address emotional and social issues through a structured programme. The unit was found to have encouraged prisoners personal development so that they can re-integrate into prison life and ensure their time spent in custody is productive and worthwhile.

The investigation team felt that this day centre approach to support people having trouble coping with prison should be promulgated across the wider prison estate.