

**Investigation into the circumstances surrounding the  
death of a man  
at HMP Hewell in October 2009**

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

**September 2010**

This is a report into the circumstances surrounding the death of a man in October 2009. He was a prisoner at HMP Hewell and died the day after he arrived. He was found hanging in his cell shortly after it was unlocked in the afternoon. He was 25 years old.

I extend my condolences to the man's family, partner and friends.

The investigation was carried out by my colleague. In addition, one of the family liaison team members has been in contact with the man's parents to tell them about the Ombudsman's investigation and ask whether they had particular questions about his time at Hewell.

I would like to thank Governor of Hewell and the prison liaison officer for their continued help and assistance throughout this investigation.

As part of the investigation, a clinical review was commissioned by the local Primary Care Trust and undertaken by a clinical reviewer. I am grateful to him and include his review as an annex to this report. The Governor, Head of Healthcare and the National Offender Management Service should consider its findings and recommendations as well as those in this report.

The man had been in prison six years earlier. On this occasion he was classed as a "Potential Category A" prisoner because of the seriousness of his offence. He was assessed as having no physical or mental problems, was not taking any medication and was not thought to be at risk of harming himself. In the hours that he spent in Hewell, no concerns were raised about his well being. Because of his categorisation, he was to be checked by staff every hour throughout the day and night.

It is possible that the man may have felt anxious about his imprisonment or the length of sentence he might receive, as well as the high prison category. He left a note addressed to his family, which indicated his intention to take his own life.

There is no doubt that the man's death is distressing for his family and friends. I hope that my report provides them with a better understanding of the events leading to the death of their son.

I make six recommendations regarding the sharing of information across the prison, first aid training and the use of medical equipment during emergencies at Hewell. In addition, I also make a national recommendation regarding the use of correct documentation by all Criminal Justice agencies that escort prisoners to and from police stations, courts and prisons.

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

**Jane Webb**

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## SUMMARY

The man was remanded in custody on 13 October 2009 by Magistrates' Court for robbery and wounding, allegedly committed on 6 October. The Prisoner Escort Record completed by the police contained a tick in the box to indicate that he was at risk of harming himself. No further details were provided. Later that day, he arrived at HMP Hewell.

On arrival at the prison, the man was received into the prison reception area. Due to the nature of the charges against him, he was deemed to meet the criteria for a Category A prisoner. He was interviewed by reception staff, which included a health screening by a registered mental health nurse. Although his mood was considered a little low, no concerns were raised by staff about his physical or mental well being. He denied having any previous or current thoughts of wanting to harm himself. He questioned his potential Category A status which meant that he was not allowed to use the telephone (to inform his family of his whereabouts). The categorisation level was explained, which was based on the seriousness of the alleged offence, together with the impact this would initially have. Prior to leaving reception, appointments were made for him to see the prison doctor and attend the Well Man Clinic for a secondary health screen the next day.

In normal circumstances, all prisoners who are new receptions at Hewell are located on the First Night Centre (Induction Unit), in house block six. The man was located on house block three because of his categorisation. As he had arrived late in the evening, his categorisation level could not be assessed by the security department until the following day.

The man spent his first night in custody on house block three without incident. The following morning (14 October), he was interviewed by a number of induction and wing staff. As he was potentially a Category A prisoner, he was observed and monitored hourly. The last recorded check was made at 12.15pm. No concerns had been raised at this point.

No further entries had been recorded by the time that the man was found hanging in his cell at approximately 2.00pm. Attempts to resuscitate him were unsuccessful, despite him being taken to outside hospital, which is where his death was pronounced.

The man's death was the first self inflicted death to occur at Hewell since Hewell was created on 24 June 2008 by the merger of three formerly separate prisons located on adjacent sites (HMP Blakenhurst, HMP Brockhill and HMP Hewell Grange).

I make six recommendations regarding the sharing of information across the prison, first aid training and the use of medical equipment during emergencies at Hewell. In addition, I also make a national recommendation regarding the use of correct documentation by all Criminal Justice agencies that escort prisoners to and from police stations, courts and prisons.



## THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened by one of the Ombudsman's investigators on 19 October 2009 when he met the Governor and some of her staff. Notices of the investigation and terms of reference had already been sent inviting anyone with any information to contact the investigator.
2. The investigator also met the Head of Healthcare, representatives of the Prison Officers' Association and a representative of the Independent Monitoring Board. He visited all parts of the prison including the house block where the man lived, and met the prison's liaison officer.
3. The man's prison records, including his medical record, were made available to the investigator during his initial visit to the prison. Additional documents were provided when he returned to conduct interviews at the prison. After the interviews were completed, the investigator fed back his initial findings to the Governor. The Governor has already started addressing some of these issues, which has been reflected within my report.
4. A clinical review of the man's medical care was commissioned from the local Primary Care Trust. I am grateful to the clinical reviewer for his review. As part of his review, the clinical reviewer jointly conducted interviews with the investigator. He also had sight of some of the interview transcripts and the man's medical records.
5. One of the Ombudsman's Family Liaison Officers contacted the man's family to inform them of the investigation. Later, with the investigator, she met the man's parents at their home to give them the opportunity to raise any questions or concerns about the care their son received. They wished to share the following information in respect of him.
  - The man's mother explained that her son had only been in prison for one day before he died and that he had never hurt himself before. She described him as a strong and happy man and expressed her concerns that the Prison Service had not taken care of him properly and had let him down. He was a loving father to a young daughter.
  - She explained that because she and her husband were in India at the time of her son's death, they were not informed for two days. She had received a telephone call from her daughter who broke the news to her. The Family Liaison Officer had explained to them that their son had nominated his partner as his next of kin and the Prison Service would have been obliged to contact her first.
  - The man's mother asked about the hand written note left by her son which she said was not in his handwriting. This is outside the Ombudsman's Terms of Reference and the police confirmed that there had been no third party involved in his death.

- The man's parents also said that the police told them that their son had been given a 'fish knife' in his prison reception pack which he used to rip the bed sheets to form a ligature. His father asked whether prisoners had access to knives. The police later explained that their information was incorrect and confirmed that prisoners are not allowed to have knives. This was reiterated by the prison liaison officer. Prison officers carry anti-ligature knives, which are commonly known as "fish knives" because of their shape.

The man's parents have been extremely distressed by the erroneous information passed to them by the police.

6. Throughout the investigation, the investigator was in contact with the police investigating officer from the Criminal Investigation Department. As the self harm marker on the Prisoner Escort Record (PER) had been ticked he requested further information to support whether the man had made any recent attempts to harm himself. The police informed the investigator that their records indicated that on 10 July 2004, the man had been arrested and taken to a police station. During his detention, the man was seen by a police doctor and he disclosed on that occasion that he had tried to self harm (no other details were recorded). The police believe that due to this, a self harm warning marker has been recorded against him, and as such, will show up whenever he is in custody.

**Comment:** Steven, you still need to explain how you attempted to find out more about the PER & that the police haven't provided the information.

## **HMP HEWELL**

7. HMP Hewell was created on 24 June 2008 by merging three separate prisons which were located on adjacent sites (HMP Blakenhurst, HMP Brockhill and HMP Hewell Grange). Hewell primarily serves the West Midlands, Worcestershire, and Warwickshire areas.
8. The new prison accommodates Category B, C, and D prisoners. There are eight house blocks, each divided into wings. House blocks one to six form the Category B prison and holds prisoners remanded by the courts, those awaiting sentence and convicted prisoners (including those sentenced to life imprisonment) to Category B status who are awaiting transfer to training prisons. Wherever possible, prisoners are allocated to a house block according to their categorisation.
9. Healthcare is provided by the local Primary Care Trust. The unit has 24 hour nursing staff, with in-patient care situated on the lower floor of the unit. All in-patients are encouraged to associate out of their cells, including eating in a communal dining area. There is a varied timetable of activities with nursing staff supporting patients to actively socialise together. A weekly multi-disciplinary meeting is held to discuss individual cases (both those who are physically and mentally ill).

## **HM Chief Inspector of Prisons report**

10. The first inspection of HMP Hewell by the HM Chief Inspector of Prisons was in November 2009. In regards to the reception and induction areas of the prison, she said:

“The reception area for house blocks one to six was busy. Revised first night procedures on house blocks one to six were not yet embedded. Insiders across the prison gave new arrivals advice and support. The induction programme on house blocks one to six had input from a relevant range of departments. Short-term resettlement plans raised during induction were often incomplete.

“There were two telephones and prisoners could make a free telephone call in reception.

“The house blocks one to six induction was a three-day rolling programme, which began the day after arrival with prisoners having the opportunity to meet staff from departments across the prison, including the counselling, assessment, referral, advice and throughcare service (CARATs), chaplaincy and healthcare, and a follow-up interview with Offender Management Unit staff. The area was busy but house block staff and Offender Management Unit staff managed the process to ensure prisoners were seen by all relevant agencies. Insiders (which I explain later) were also present throughout the morning to provide support.

“During these interviews, staff were supposed to complete the appropriate section of the prisoner’s short-term resettlement plan to document his identified needs and any action taken. Although onward referrals were made from these interviews, this was not indicated in the plans we viewed, many of which were incomplete.”

### **Categorisation of prisoners**

11. On arrival into prison, prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels of category which are A, B, C and D, with Category A prisoners presenting the highest risk.
12. Category A prisoners are those who, if they escaped, would be highly dangerous to the public, the police or to the security of the state. Category A prisoners are dispersed within the high security estate. All prisoners deemed as an exceptional risk are housed in Special Security Units (SSU) within a high security prisons.
13. On arrival at Hewell, local procedures state that the reception and induction process will identify prisoners charged with one or more of the offences on the Prison Service Category A list. The offences committed by the man, robbery and wounding, met this criteria and so he was designated as a “Potential Category A” prisoner. Staff identifying these prisoners complete the Reporting of Potential Category A Prisoners form. The completed form is passed to the Duty Governor to decide where the prisoner should be located. These prisoners initially wear a blue and yellow prison tracksuit and are escorted on any movements around the prison. Even though they are on remand, they are not allowed to keep their own clothing. All their telephone calls are monitored and recorded.
14. All cells in house blocks one to five are built to Category A standard and the Duty Governor usually allocates potential Category A prisoners to house blocks one to three.
15. A record of movements (yellow booklet OB001) is opened immediately for all prisoners reported as potential Category A, and is maintained until their categorisation is reviewed. It is a continuous, auditable record of the supervision, location and movement of prisoners who are potentially Category A. The prisoner is checked every hour, 24 hours a day, with the observations recorded and signed in the booklet. The checking procedures include:

“The officer taking responsibility for a potential Category A prisoner will check the identity of the prisoner with the photograph in the booklet.

“The officer will record the date, time and location upon receipt and handover of the prisoner and sign to that effect.

“This process will be repeated on every occasion that responsibility for the prisoner changes.”

### **Access to telephones**

16. Pin telephones are used in prisons and each prisoner is given a PIN number which they key in before making a call. Prisoners may complete a form to select telephone numbers for their family, friends and legal contacts, which has to be agreed by the prison. Outside the high security estate and dependant on the prisoner's category, they may make telephone calls to their contacts without the number being agreed beforehand. The system works on a credit basis and prisoners buy credit from the prison shop, the cost of the calls being automatically deducted from their PIN account.
17. Hewell's local procedures state that prisoners identified as potentially Category A are permitted normal access to PIN phones. Exceptional Risk Category A prisoners (which the man was not) are not given access to PIN phones.

### **Cell sharing risk assessment (CSRA)**

18. In order to make sure that unsuitable prisoners do not share cells, a cell sharing risk assessment is completed by reception staff when a prisoner first arrives at the prison.

### **Prisoner Escort Record (PER)**

19. The police, courts, escort and prison services have an agreed procedure for sharing information about prisoners as they are moved between their establishments. It is essential that, when a prisoner is moved from police station, court or prison to court, prison, hospital or other destination, those responsible for the prisoner are made aware of any risks or vulnerabilities. In particular it is essential that known risks of escape, assault, suicide/self harm or harassment are communicated to others into whose custody the prisoner is passed; to protect prisoners, staff and the public. It is also essential that any new risks that develop during a movement are recorded and flagged up for others. The PER is the key vehicle for ensuring that information about the risks posed by prisoners on external movement from prisons or transferred within the criminal justice system is always available to those responsible for their custody.

### **Reception**

20. When prisoners arrive at the prison, all their paperwork is checked before they are taken off the escort vehicle. Staff check the warrant to ensure that the correct prisoners are in custody, and then prepare the necessary records. The prisoner is taken from the vehicle and booked in by the senior officer on the front reception desk. Personal and offence

details are taken, along with any known concerns. Reception staff do not have access to any previous custodial history at this time.

21. All prisoners see the first night in prison officer, reception officers, and the nurse on duty. During this process, staff obtain their address and next of kin details. Prisoners can choose who to name as their next of kin and do not necessarily identify the person who is their legal next of kin. They are normally entitled to make a free telephone call from reception so that they can inform someone of their whereabouts.
22. New prisoners are allocated a prisoner number, irrespective of whether they have been in prison before. They are strip searched, their property is logged, and they are health screened, before being placed in a holding cell, ready for staff to take them to a house block.
23. Prisoners are interviewed by a range of staff in order to identify any immediate needs and risks. They are also interviewed by an Insider or a Listener.

### **Insiders and Listeners**

24. Hewell recruits experienced prisoners to operate as Insiders and Listeners. Insiders welcome new prisoners, highlight any concerns and explain the processes they will encounter in the early days of custody. Listeners assist those prisoners who require additional support at any time in their period in custody. They are trained by the Samaritans and required to provide confidential support.

### **Roll check**

25. The roll check is the physical count of the number of prisoners on each wing within a prison. Roll checks occur at specified times during the day, and staff must sign that the roll is correct. Hewell's local procedures state that roll checks should be carried out at 6.00am, 12.30pm, 5.30pm and 8.00pm.

### **Assessment, Care in Custody and Teamwork (ACCT)**

26. The ACCT system monitors and supports prisoners who are assessed as at risk of suicide or self harm. Once placed on ACCT, the prisoner is observed at intervals determined by their perceived level of risk. The observations continue during the day and the night. Additional support is offered from Listeners, personal officers and other staff. Amongst other things, the ACCT guidance states that prisoners should be cared for in a safe environment. It is for the case review team to decide the most appropriate place to locate an individual prisoner within a prison. The arrangements are reviewed regularly by a multi disciplinary meeting, which includes the prisoner.

### **Counselling, Assessment, Referral, Advice and Throughcare (CARATS)**

27. Organisations specialising in the treatment of substance abuse have drugs workers based in most prisons. CARATS workers run programmes and offer counselling and support to prisoners. Access to the CARATS service is voluntary, by application of a prisoner.

## KEY FINDINGS

### The man's arrival at Hewell

28. The man was arrested on 12 October 2009 for an offence of robbery and wounding committed six days earlier and was remanded into police custody. The following day, he was escorted by Reliance Security Group (RSG) to appear at Magistrates' Court.
29. As with all prisoner escorted journeys between police stations, courts and prisons, a Prisoner Escort Record (PER) form was completed and passed on by the police to RSG. On the man's PER form, under the category headed "Risk Categories", the self harm box was ticked. No further details as to why the self harm box had been ticked were given. From documentation provided to the investigator, it was noted that his Police National Computer printout highlighted that he had "attempted self harm" in July 2004.
30. Following the man's court appearance, he was remanded into prison custody. In normal circumstances, he would have gone to HMP Birmingham. Instead he was remanded to HMP Hewell because his alleged co-defendant had been remanded to Birmingham.
31. A Senior Officer (SO) explained at interview that a full first night screening process is undertaken by reception and healthcare staff. The man would have been familiar with the process as it is similar in every prison. The staff conduct a dedicated first night interview and complete pages one and two of the short-term resettlement plan, which contains personal details about the prisoner. Any concerns about self-harm or suicide should be identified and appropriate action, such as opening an ACCT document, is taken by staff. Most prisoners are located on the induction wings where they stay for approximately two days. During this time, their induction and familiarisation to the prison continues including sessions by a number of agencies such as the YMCA (a charity which supports young people), Citizens Advice Bureau and education.
32. The man arrived at the reception area at around 6.45pm where he went through the prisoner reception process. Because of the nature of the charges against him, he was deemed to meet the Prison Service criteria for a potential Category A prisoner.
33. On the evening that the man arrived, an officer was carrying out the duties of entering prisoner information on the computer and taking their photographs. This is one of the first tasks completed when a prisoner arrives. He completed the "First Night Canteen and an Initial Telephone Requirement". He did not discuss the man's category status with him at this point. He took his photograph and asked if he wanted any canteen (such as snack food, tobacco and telephone credit). As the man only had £1.50 with him, he was advanced £5.50 which is the normal procedure. He asked for a smoker's pack (tobacco, cigarette papers

and a lighter) and a single telephone PIN credit to the value of £1.50. The officer circled the answer “YES” to the question “Initial Telephone Call Offered” which is listed on the form. The man did not report any concerns to the officer and he continued through the reception process.

34. The officer told the investigator that all prisoners are normally offered a two minute telephone call, free of charge, in reception which is usually the last stage in the reception process. The facility is not granted to a potential Category A prisoner or if they are charged with some forms of harassment. The officer did not know whether the man was offered a telephone call later. The officer also expected that, at some point during the man’s reception screening, an officer from the security department would interview him for the Potential Category A booklet.
35. A second officer was also on duty in the reception area and he interviewed the man shortly afterwards. He told the investigator that it was a busy evening and the man stood out from the other prisoners because of his “very polite and well spoken” manner. Whilst he interviewed him, the officer had a copy of his PER in his possession. The man provided good eye contact, meaning that he appeared relaxed, and answered the questions put to him by the officer clearly. They went through the cell sharing risk assessment (CSRA) document and the man said that he had last been in prison six years before, was a smoker and had previously abused alcohol. When the officer referred to the self harm box which was ticked on the PER document, the man denied having ever harmed himself.
36. The second officer told the man that the status of potential Category A was applicable because of the seriousness of the charge against him and the potential threat to the security of the establishment. These procedures were part of the Local Security Strategy. The man was concerned about his categorisation and said “I’m not a bad person”, to which the officer replied that the categorisation did not necessarily mean that he was bad. He also informed him that he would have to wear a prison issue blue and yellow tracksuit, and be escorted on any movements around the prison. He would not be allowed a telephone call that evening, until his category status had been confirmed.
37. The man repeated that he was “not a bad person”, and the second officer tried to reassure him by saying that his status might be changed the following day once staff had time to check it. He said that, given the time of the evening when the man arrived, security staff would begin to make the necessary enquiries into his offence the next day. As the man appeared concerned about his status, the officer wrote on the CSRA form “Very concerned at being potential Cat A at present”. He had no other concerns about the man and did not judge that he was at risk of harming himself. He also assessed that he was a “Low” risk for sharing a cell with others.
38. The second officer noted that the man’s “mood was good” and he was “very responsive”. He asked if he could speak with his girlfriend and the

officer explained again that this would not be possible until the following day. He accepted this and the officer said he had no concerns about him. He told the investigator that he did not know where the man would be located, but a member of the reception staff would normally check to see where there was space for a potential Category A prisoner.

39. At interview with the investigator, a governor said that she was the duty governor on the evening that the man arrived. She had been alerted by Birmingham prison that he was to be remanded at Hewell. She said that when a potential Category A prisoner is identified in reception, it is the duty governor's responsibility to make sure that the rest of the management team are aware, which generally happens the following morning, and also to ensure that the prisoner is appropriately located.
40. The duty governor was contacted by a member of staff in reception and told about the man. She accepted the recommendation that he was a potential Category A prisoner and made sure that he would be appropriately located in one of the house blocks. She said she would not necessarily meet potential Category A prisoners. However, as part of her duties, she would visit all the prison wings and check that there were no concerns about such prisoners.
41. Hewell's local procedure "Control & Management of Potential Category A Prisoners" states that when a prisoner is identified as potential Category A, staff should complete the pro-forma entitled "Reporting of Potential Category A Prisoners". The completed form is passed to the duty governor to decide where they should be located. The form requires that the prisoner is fully briefed about their category status and the impact it will have on them. The form also requires that the completed form is signed by the prisoner and the duty governor and a copy given to the prisoner. (Although the man's name was written on the pro-forma, neither he nor the duty governor signed it.) She told the investigator that she had no contact with him.

#### **The man's contact with healthcare**

42. As part of the reception process, at 8.31pm the man received an initial primary health screen examination by a Registered Mental Health Nurse (RMN). The purpose of the initial reception health screen is to:
  - Ensure that any immediate health needs are assessed and care provided as appropriate.
  - To assess the level of any substance use/misuse.
  - To assess the level of risk of self harm and or suicide.
43. System One is an electronic patient record system that is used at Hewell (and some other prisons) as the clinical record. The initial health reception screen is built into the system as a template.
44. At interview with the investigator and the clinical reviewer, the RMN confirmed that he assessed the man. He recorded that the man had

been in prison in the past, and had been previously treated for depression, which they discussed during the interview. The man had not been referred to any mental health services in the community and had not been in hospital. He reported that he had no history of harming himself but that he was not happy about being in prison. The RMN told the investigator that he did not have sight of the PER form and so was unaware that the self harm box had been ticked. He added that he would have preferred to be at HMP Birmingham. He described his family as supportive and wanted to telephone them to inform them of his whereabouts and relieve his anxiety.

45. In reference to alcohol use, the man admitted drinking approximately 40 units a week which he had consumed in the previous week before coming to Hewell. He had also used cannabis and cocaine previously. Nonetheless, he said he had no concerns about his health before being remanded in custody. He was not taking any prescribed medication and had no outstanding hospital or other health related appointments. The RMN assessed that the man was fit and well, suitable for normal location, work and to share a cell. No medical or psychiatric reports had been requested by the court and no information had been received from an outside source.
46. In addition, the RMN made the following observations about the man:
  - “Emotional state observation - Low in mood.
  - Impressions of the prisoner’s behaviour and mental state - Low in mood.”
47. The RMN clarified that he used a scaled question to establish the man’s mood. The question asks the prisoner to score their mood with one being happy and ten being very low in mood. He told the nurse that he scored seven. The RMN told the investigator that, if he thought the man was at risk of suicide or self-harm, he would have opened an ACCT document.
48. As is customary, the man was booked for two routine appointments for the following day. They were with the prison doctor (a general practitioner) and the Well Man clinic where he would have a secondary health screen. The RMN also booked an appointment for him to see another mental health nurse. As he did not know whether the man was to be located in the segregation unit (as happens to some potential Category A prisoners whilst their category is decided), he also completed a segregation unit algorithm. (A nurse must complete a safety algorithm to determine whether there are any medical reasons to keep the prisoner out of segregation.) He completed his interview with the man at around 8.50pm.
49. Under normal circumstances, the RMN said the man would have been seen the following morning (14 October) for his appointments. However, because of his category status and as he was not located on the

induction wing, his appointments were in the afternoon at 3.20pm and 3.00pm. (Neither the investigator nor the clinical reviewer found a diary entry for the mental health assessment on the electronic diary system of System One.)

50. One of the Offender Management Unit's responsibilities is to conduct a first night care interview on the evening a prisoner arrives. A third officer was based on house block six with a colleague, when she was informed that a potential Category A prisoner was in reception. Knowing that such prisoners would not be on house block six, she made her way to reception to interview him.
51. The third officer told the investigator that she arrived in reception around 8.50pm as staff finished interviewing the man. She interviewed him as well and went through the first night in custody induction checklist, which included identifying whether he was at risk of harming himself. He said he had no thoughts of wanting to harm himself, either at the time or previously. He also denied having any drug or alcohol issues. The officer confirmed that the man had not been offered a telephone call because of his potential Category A status. In response to questions on the induction checklist relating to whether he had telephoned anyone and whether his family knew where he was, she circled the answer "NO" to both. The latter answer also included the words "Pot Cat A" written next to it.
52. The interview with the man lasted around ten minutes, the officer wanting to identify whether he had any urgent needs that should be addressed before he was locked in his cell. She described him as "quite chatty", asking random questions about sentencing, the prison and that his offence was being considered as Category A. Knowing that reception staff had already explained his status to him, she reiterated that it was because of the seriousness of the alleged offence. She said that his categorisation would be assessed over the next 12 hours or so, and he would be informed if it was to remain the same. She told him that, in her opinion, it was unlikely that he would be a Category A status prisoner.
53. The third officer said she had sight of the man's wing file (created in reception) which would have included his cell sharing risk assessment (CSRA) document. She did not, however, see his PER form and so was unaware of the self harm marker.
54. In respect of telephone calls by potential Category A prisoners, the Security Governor said that the man would have been entitled to make a call when he arrived in reception. However, the prison's procedures stipulate that the call should be monitored even though there is no facility to do so. This meant that the man was not allowed to make a call. He confirmed that the local procedures do not exclude a member of staff making a call on behalf of the prisoner, although there is no evidence that this was considered.

55. When the third officer concluded her interview with the man, she was informed by a member of staff in reception that there was a space on house block three (A spur). He had not been interviewed by either an Insider or a Listener. The officer escorted him to the house block with another officer. On route, he was still chatty and asked when he would be able to get out of his prison issue clothes, which he had been issued with at reception.
56. A fourth officer worked on house block three. He told the investigator that the house block has three spurs (A, B, and C), holding approximately 200 prisoners in standard prison cells. The majority of the prisoners were sentenced and attend education classes and prison workshops during the day. House block three is occasionally used for remand prisoners when there are pressures on the prison numbers. In addition, three of the cells on A spur second landing (cell numbers two to four) accommodate potential Category A prisoners.
57. Just before the man was taken to house block three, the fourth officer said he received a telephone call from reception informing him that a potential Category A prisoner was to be located on the unit. As the officer left the house block to go off duty, he saw two officers escorting the man towards the entrance.

#### **The man's arrival on house block three**

58. The Operation Support Grade (OSG) told the investigator that his night duty began at 8.45pm, continuing until 7.45am the following morning. After he arrived on the wing, he received a handover from the day shift staff and no concerns were reported. He checked that all the cells on the house block were locked, bolted and secure. He also checked those prisoners on ACCTs and any potential Category As. Referring to potential Category A prisoners, the OSG knew they were to be checked every hour and their booklet signed in confirmation.
59. The OSG recorded in the wing observation book that the man reached house block three at 9.10pm, escorted by two officers from reception. He was wearing the Category A uniform. The third officer had a brief conversation with the OSG about the man's status and where he was to be located. The escort officers did not bring the potential Category A booklet with them. The third officer told the investigator that the booklet is normally generated by the security department. On this particular evening, she was told none were available from security or reception. She suggested to the OSG that he should note his hourly checks on a piece of paper.
60. The man was taken to his cell where the third officer asked him to remove his prison issue clothes and trainers. They would be stored outside his cell because potential Category A prisoners are not allowed to keep the clothing in their cell overnight. The clothes would be handed

back in the morning when his cell was unlocked. Before his cell was locked, he was given a kit bag which contained bedding, underwear, socks and a tea pack.

61. Whilst the officers took the man to his single cell, number A2 04, the OSG completed the paperwork in the office. He overheard the officers asking the man to remove his shoes, something he appeared unhappy about.
62. The Security Governor told the investigator that all potential Category A prisoners should have a yellow booklet. The booklets are kept in the security department, although the reception area holds a small supply for the occasion when no-one is in the security department to issue one. On the evening when the man arrived, a booklet was not issued. The investigator was told this was because no security staff were available and reception had run out of booklets.
63. After the man was locked in his cell, the escort staff returned to the office, telling the OSG that they were leaving the wing. The OSG went to check that the cell was fully locked and bolted. He opened the hatch on the cell door and asked the man if he was okay, to which he replied that he was fine but wanted a television. The OSG told him that he should make the request to the day staff the following day. He informed him that he would check him every hour and would try not to disturb him by using the cell night light. The man did not respond or raise any other concerns.
64. During the night, the OSG checked the prisoners on ACCT documents regularly, as well as checking the man every hour. No concerns were reported. He said that he signed the piece of paper he had made up to confirm his checks of him. The night passed without incident. When a second SO made his routine management checks, the OSG said he told him that the checks were recorded on a piece of paper as the yellow Category A booklet was unavailable.
65. When the OSG's night shift duty concluded around 7.35am, he handed over to the day shift staff without incident. He said that the piece of paper used to record his checks was placed with the wing observation book. (The investigator has not been provided with a copy of the record which the OSG compiled.) He confirmed to the investigator that he did not carry out a roll check before leaving the wing as this was the responsibility of the day staff.

### **Events on 14 October**

66. A third Senior Officer (SO) told the investigator that she knew that the man had arrived on house block three quite late the previous evening. When she arrived for her duty on the morning of 14 October, she informed the fourth officer, who was rostered to work on house block three A Spur, of the man's status. She asked him to speak to the man to

check that he was okay and ask whether he had any concerns about his potential Category A status.

67. The fourth officer had arrived around 8.00am for duty on house block three. Having been briefed by the third SO, he conducted a roll check and unlocked the cells at around 8.15am. Although he could not remember clearly, he believed that a potential Category A booklet for the man had been obtained as one was in the wing office. He recorded the checks in the booklet, the first being at 8.15am.
68. When the fourth officer unlocked the man's cell (between 8.15am and 8.30am), he went inside to introduce himself and return his prison clothing. The officer explained that the man would have to wear Category A uniform during the day and it would be removed during the night.
69. The fourth officer described the man as polite, respectful and friendly and he asked some general questions during their short conversation. His main concern was to know when he could make a telephone call and how long he would be a potential Category A prisoner. The officer told him that his status would be confirmed very soon, probably later in the day. He thought it likely that his potential Category A status would be removed and he would be transferred to the induction unit. The officer told him that he would make enquiries during the day to see whether the security staff had completed their checks.
70. The man was concerned about his family and wanted to telephone to let them know where he was. The fourth officer explained that his potential Category A status precluded him from using the prison telephones but, as soon as his status was clarified, he could make a telephone call. He thanked the officer and appeared to be "quite happy" with the responses to his concerns.
71. The fourth officer told the man that if he had any further questions or problems, staff were available every morning in the landing office to assist him. The officer unlocked the remainder of the cells and also arranged for him to be given a breakfast pack. This had not happened the previous evening as he arrived late on the wing.
72. As promised, the fourth officer later contacted the security department to enquire about the man's status. He spoke to a fourth SO who came down to house block three (around 10.30am) to speak to him. The SO told him that, although all the checks were incomplete, it was probable that the man's potential Category A status would be lifted by the afternoon and he could then move to the induction unit. The officer said that he immediately relayed this information to the man.
73. The fourth officer reported no concerns throughout the morning. Although there are no entries on the man's wing history sheet or his induction booklet, he said that a number of staff from outside the unit visited to deliver parts of his induction programme. From memory, he said that representatives from the induction, CARAT and resettlement teams spoke to the man. Each time that he

escorted a member of staff to the man's cell, he was in a good mood and raised no concerns. Another wing officer met the man during the morning in order to confirm some details. The officer said that no problems were reported and he seemed fine.

74. Prisoners are normally issued with a set of plastic cutlery (plate, bowl and fork) when they arrive on the wings. However, because the man had arrived late, he did not receive one. Sometime around 11.00am, he accompanied the fourth officer to the store room to retrieve his cutlery. The third SO opened a gate for him on his return and told the investigator that she had no cause for concern about the man's demeanour.
75. Between 11.30am and midday, all the prisoners including the man collected their lunch and were locked back into their cells. It was around this time that a fellow prisoner said that he spoke to him. He told the investigator that he knew him from school. They spoke briefly and the prisoner said that the man's mood looked "down". The man mentioned that he was unsure about the length of sentence, which he said might include an indeterminate sentence for public protection (IPP). (An IPP sentence requires prisoners to serve the minimum term for their offence, and the Parole Board then assess their case for release.)
76. The fourth officer said he last checked the man (and logged this in the yellow booklet) at 12.15pm. He had no concerns about him. Most prison staff take their lunch break between 12.30pm and 1.30pm. The officer left the wing soon after checking the man and verbally handing over to the lunch time staff, the fifth officer. The fourth officer said that he expected that the next check of the man would be at 1.15pm by the fifth officer.
77. The fifth officer was not available to be interviewed in person but the investigator was able to talk to him on the telephone at a later date. The officer said that he had worked on house block during the morning and knew about the man's potential Category A status. The officer was familiar with the potential Category A yellow booklet, its purpose and that prisoners should be checked every hour. However, there were no entries made during the period when he was covering the lunch time shift. The officer said he checked the man at 1.10pm and he had no concerns to raise. He had not recorded this in the booklet because he was "side tracked" by responding to another prisoner's cell bell. Shortly afterwards, he was relieved by the staff returning from their lunch and he returned to his normal duties on house block three, B spur.
78. At interview with the investigator, a sixth officer said that he came on duty on house block three, A Spur at 1.30pm and was briefed by the SO on duty. He knew that there was a potential Category A prisoner on the wing, and the man's name was highlighted on the office board. He also noticed the yellow Category A booklet in the office. Although he did not make the checks himself, he said that the man should have been checked just before prisoners were unlocked at around 1.30pm, although

he was unsure who did so. The next check would be after prisoners went back to their cells approximately an hour later.

79. The fourth officer returned from his lunch break shortly after 1.30pm and, with the sixth officer, started to unlock the wing, taking around 15 minutes to do so. Prisoners who were due at work were searched and then sent to their workshops.
80. After both officers completed their initial tasks, they began to lock the cells of the remaining prisoners. They started with the cells on A spur on the second landing. As the sixth officer arrived at the man's cell (number four), he glanced inside and saw that the curtain was closed. He saw the man's potential Category A blue and yellow tracksuit over the back of the chair. As he was not allowed to leave his cell without wearing these clothes, the officer looked quickly down the landing to see if he had left his cell. Not seeing him, the officer looked back to study the cell. He noticed that, at the back of the cell, the curtain was draped between the toilet and was covering the end of the bunk bed. He saw the man and immediately shouted for the fourth officer, who was on the opposite side of the landing, to assist him.
81. The sixth officer was not carrying a radio and so, whilst the fourth officer ran to help, he asked him to use his radio to call a Code Blue emergency alarm (logged at 2.00pm). This code means that someone is having difficulty breathing and requests immediate assistance from the healthcare team.
82. The officers went into the cell together. The sixth officer pulled back the curtain (which was covering the end of the bunk bed) and saw a ligature (made from what he thought was bed sheets) tied from the top of the bed, on the end between the toilet and the end of the bed. The man was hanging between the toilet and the end of the bed.
83. Whilst the fourth officer radioed for emergency assistance, the sixth officer quickly used his anti-ligature knife to cut the ligature. He supported the man's body and lowered him to the floor. A seventh officer arrived and helped the sixth officer remove the ligature from the man's neck. The third SO also reached the cell and, with the fourth officer, remained at the door to offer assistance and ensure that there was no unauthorised entry into the cell. The SO asked a member of staff to collect the emergency box from the wing office.
84. Having had recent first aid training, the seventh officer took the lead in attending to the man. Once the ligature had been removed, he checked for any signs of life but could not find a pulse. The man had vomited and, wanting to commence cardio pulmonary resuscitation (CPR), the seventh officer cleared his mouth and airway with his fingers. He did not have a mouth guard and improvised a "mouth piece" out of a toilet roll insert. He placed it over the man's mouth to avoid any direct contact and

gave two breaths through the tube. This was followed by 15 chest compressions. Not being successful using the toilet roll, the sixth officer tried to assist by putting toilet paper over the man's mouth to act as a barrier, whilst he supported his head.

85. CPR continued and the emergency box, containing a face mask, arrived very quickly. The third SO told the investigator that, although she had not had recent first aid training, she felt confident about her ability to deliver CPR. She relieved the sixth officer (who had not had recent training and was less confident) and used the face mask to begin administering breaths, whilst the SO delivered chest compressions. The staff continued CPR until healthcare staff arrived.
86. The Principal Officer (PO) was the orderly officer in charge of the prison. He heard the Code Blue emergency alarm broadcast over the radio network and sent his assistant, another PO, to attend. The PO reached the man's cell moments after the second PO and saw the two officers carrying out CPR. The first PO Mole immediately contacted the control room to request an ambulance. As the landing became busy with staff arriving to assist, he remained there to control the situation. A log keeper was assigned to keep a record of those who entered and left the cell.
87. A Registered General Nurse (RGN) was at a staff meeting in the healthcare centre when she received a Hotel Three Code Blue emergency call on her radio. (Hotel Three is the radio carried by the member of healthcare who is the first to respond to emergency calls.) She told the investigator that she immediately collected the emergency equipment bag from the healthcare centre and made her way to house block three, arriving within two minutes of receiving the call.
88. The RGN went into the man's cell, where she saw the officers carrying out CPR. Whilst being briefed on the situation, she entered an airway and put a bag and mask on to his mouth to assist his oxygen intake. She asked for an ambulance to be called and told the officers to continue CPR whilst she got the rest of the emergency equipment ready. She realised that the seventh officer was carrying out chest compressions at a ratio of 15 to a breath. She knew that the ratio was incorrect and that guidelines stipulate that 30 chest compressions should be given. She instructed him to increase the compression ratio to 30 compressions for every two breaths. The third SO administered oxygen via the bag in between compressions. The RGN checked the man for signs of life but found that he was not breathing, had no cardiac output, there was no pulse and his pupils were fixed and dilated. There were no signs of rigor mortis. She requested more medical equipment and CPR continued.
89. The RGN was joined very quickly by two more nurses. One of the nurses told the investigator that she knew that the RMN had responded to the emergency call and heard the request for further medical

equipment over the radio. Aware that the RMN had not taken the defibrillator with her, she collected it and immediately made her way to the cell. (A defibrillator is a machine which delivers electric shocks to restart the heart.)

90. The nurse also told the investigator that the man showed no signs of life. CPR continued and, using the defibrillator, his condition was assessed every two minutes. There was no change to his condition. The defibrillator pads were again attached to him and showed that he was in a "non shockable rhythm". With the nurses in control, the officers left the cell and assisted other staff on the landing. A privacy screen was placed around the entrance of the cell and the prisoners on the landings were returned to their cells.
91. The prison doctor arrived at the man's cell at 2.20pm. At interview with the investigator, he said that he was alerted to the emergency by other staff. When he arrived, the nurses were already carrying out CPR and assessing his condition as they tried to resuscitate him. He was given an update and was on hand to give any assistance that was required.
92. The paramedics arrived by 2.24pm and, with the nurses, continued CPR using some of their equipment. The nurse left the cell to give the paramedics more room to work in. The paramedics made the decision to take the man to hospital and, whilst CPR continued, they prepared him to be taken by ambulance.
93. Three officers arrived to offer assistance. They checked the welfare of other prisoners whilst the paramedics continued to try to resuscitate the man. An eighth officer told the investigator that, with the two other officers, they were assigned to escort the man to outside hospital. The paramedics left the cell with him at 2.40pm. CPR continued whilst he was taken from the cell to the ambulance and during the journey to the hospital.
94. The second PO told the healthcare staff to leave all their equipment in the cell, which would be sealed with a padlock to await the arrival of the police. Prior to their departure, healthcare staff found a hand written note in the cell. The note said:

"To all the people I love and my special mum and dad. I'm sorry for being bad!! I must go now coz I can take this life no more please let these people no love you all  
xxx"
95. The eighth officer said that the ambulance arrived at the hospital at 3.00pm and the man was taken immediately to the resuscitation area. Within a couple of minutes, the hospital doctor confirmed his death at 3.03pm.

## **After the man's death**

96. The first PO immediately instigated the prison's death in custody procedures and ensured that all the relevant agencies were notified of the man's death. The staff who tried to resuscitate him were also informed. A hot debrief meeting was held at approximately 4.00pm, which was chaired by the Deputy Governor. Most of the staff who responded to the emergency were there and they were given the opportunity to discuss the morning's events. The staff care and welfare team were invited to offer support to staff.
97. The Security Governor confirmed to the investigator that, early in the afternoon, the security department completed their checks to verify whether the man's offence qualified for him to be a Category A prisoner. The checks confirmed that he would not have been given Category A status.
98. The prisoners on the man's wing were offered support if his death had affected them. Those being monitored by the ACCT procedures were reviewed to ensure their well-being.
99. The man's next of kin was identified from prison records as his partner. Around 4.00pm, the Governor, the family liaison officer and chaplain visited his partner to inform her of his death. Later that evening, the police also visited her.
100. Over the next 24 hours, both the police and the family liaison officer tried to contact the man's family. They spoke to two of his sisters and an uncle. His parents were on holiday in India and they were told of their son's death by the man's sister. They returned to the United Kingdom on 18 October and liaised with the prison, police and the coroner. They were able to view his body the following day, Monday 19 October. After discussions involving his parents, the coroner, the prison and his partner, it was agreed that the man's parents would act as the next of kin and be the main point of contact. The man's partner kept in contact with his parents and the prison offered financial assistance towards the funeral expenses.
101. The prison held a critical debrief meeting a few weeks after the man died. The staff interviewed by the investigator said that they benefited from the meeting which gave them a better insight into the circumstances leading up to his death.

## ISSUES RAISED IN THE INVESTIGATION

### Clinical care

102. The clinical review was conducted by a clinical reviewer and makes 12 recommendations. I refer to those which are most pertinent to my investigation. The clinical review will also be shared with the Primary Care Trust.

### Prisoner Escort Record

103. I have already mentioned that the PER is the key vehicle for ensuring that information about the risks posed by prisoners on external movement from prisons is always available to those responsible for their custody. Certainly in the man's case, a risk of self harm was noted on the PER. What was missing was the explanation to support this which could have assisted further those who he came into contact with (after leaving the police station), in making decisions about his current risk level. The investigator, having reviewed the PNC printout and contacted the police, has gained no further information about their judgement that he had any current or recent thoughts of harming himself. Although the self harm box was ticked, no further details have been provided and I do not know what, if anything, occurred at the police station, to explain the record.
104. Prison Service Order 1025 issued on 1 May 2009, introduced a new PER document to be used when escorting prisoners within the Criminal Justice system. The form provides a space for "All relevant information regarding risk is commented on fully within the document", which is in contrast to having just a tick box on the old form. For whatever reason, the new PER form was not used for the man and as mentioned, no details about the apparent risk of self harm were recorded.
105. It is essential that all escort staff and receiving agencies are equipped with information, particularly risk information, relating to a prisoner prior to and during the escort procedure.

**National Offender Management Service should ensure that all Criminal Justice Service agencies who escort prisoners on external movement or transfer from or between prison establishments are using the new style (A4) PER, under the guidance of the new PSO 1025.**

106. Notwithstanding the above, the man was comprehensively and adequately assessed in reception by the RMN who completed the reception health screen. Although the PER is not usually passed to healthcare staff, I believe that, on this occasion, it would have been appropriate, given that the box referring to "Self Harm" had been ticked. Had the PER been shared with him, the RMN might well have asked him about the reference. Nevertheless, he was booked to see the general

practitioner and a general nurse the following day. Even without being aware of the PER warning, any of these medical staff could have identified concerns about his mental health. The RMN was not concerned that the man would harm himself and the other appointments had not taken place when he took his life.

107. I make the following additional recommendation regarding the PER document.

**The Governor should ensure that any information relating to risk of self harm is shared with all the staff, including healthcare staff, in reception and the induction unit. In particular staff should share any significant information from the Prisoner Escort Record (PER).**

108. The services provided in house block six, the induction/first night centre, are comprehensive and directly aimed at new prisoners. However, as the man was a potential Category A prisoner, he was not placed there and instead was located in house block three. This is a normal residential wing and it might be thought that he could be disadvantaged from a healthcare perspective by being located there. Had he been located with other new prisoners in house block six, the medical appointments would have taken place the morning after he came into custody. Instead the appointments were scheduled for the afternoon.
109. I do not believe that the delay is likely to have affected the man's thoughts during the morning. I am conscious of the security constraints the prison faces and the resource implications of locating all new prisoners, irrespective of their category, on the first night centre. The appointments were only postponed by a few hours and I do not consider that the delay had any bearing on his decision to take his life.

### **Potential Category A status**

110. The principles of Hewell's local policy "Control & Management of Potential Category A Prisoners" were, in the main, applied to the man. He was told about the categorisation decision a number of times during his reception screening. However, the procedures also state that the pro-forma "Potential Category A Record of prisoner notification" should be completed. The document was incomplete as neither he nor the Duty Governor had signed it (which would have confirmed that they had both seen the document). There is no recorded evidence that he was given a copy of the document, again something which is required by the procedure. The Governor explained that the form should be completed as soon as possible following a prisoner's admission. However, this can be the next day depending on when the prisoner arrives. Duty Governors were aware of the requirement to complete the document, and the Governor has since issued a notice to all staff reminding them of this requirement. I note the Governor's swift action on this matter.

111. The prison's procedures allow potential Category A prisoners to make telephone calls, stipulating that they should be recorded and monitored. These prisoners are permitted normal access to any PIN telephones which can be monitored. The telephones in reception do record however because staff input a generic personal identification number (PIN) for reception calls to be made, it is impossible to identify the person using the phone if you were to listen to the recording of it. The man was therefore not allowed to telephone his family to tell them where he was even though he wanted to do so.
112. Although reception staff correctly applied the policy, the investigator was informed by the security manager that it would not necessarily preclude them from making a call on behalf of a prisoner. I am aware of the heightened security issue risks surrounding potential Category A prisoners. And I am also aware that a prisoner's first few days in prison custody can often be when they are most vulnerable. Unless there is a specific security risk, I believe that reception staff should contact the potential Category A prisoner's next of kin on their behalf. The gesture would I believe help to alleviate any of the prisoner's anxieties.

**The Governor should ensure that prisoners arriving at Hewell can tell their next of kin of their whereabouts, regardless of their security category.**

### **Listeners and Insiders**

113. Usually new prisoners are interviewed by an Insider or a Listener. The investigator has found no evidence that the man was seen by either. The prison's safer custody officer said that he was taken straight to house block three without seeing a Listener. The Insiders were also unaware that he was in reception.
114. Listeners and Insiders form a unique part of prison society, helping and advising new prisoners about issues they may have about prison life. Using their experience and status within the prison, they can offer confidential reassurance. Whether the man would have benefited from seeing a Listener or Insider is unknown. However, he was mistakenly denied access to them and missed the opportunity to use their services. Following his death, the Governor informed the investigator that new procedures have been implemented to ensure that new prisoners are all seen by a Listener or an Insider. I therefore make no recommendation on this point and again note the Governor's swift action to rectify the omission.

### **Induction**

115. The man's induction continued the following morning when he was seen by a number of staff from agencies within the prison who visited the house block to talk to him. Their contact was not reflected in his induction booklet, which was largely blank. It is important that significant

contact between staff and prisoners, especially during their first days in custody, is recorded so that it can be shared amongst interested parties.

**The Governor should remind staff of the importance of recording their contact with prisoners, especially during the induction period.**

### **Potential Category A prisoners**

116. The "Control and Management of Potential Category A Prisoner" procedures refers to the movement and control of potential category A prisoners. One requirement is that, whilst locked in their cells, the prisoner is checked at least once an hour, both day and night. A record of the observation should be recorded in the OB001 (yellow booklet).
117. When the man arrived at Hewell, none of the booklets were available. They are kept in the security department with a small supply in the reception area. On this occasion, it appears that none of the security staff were available and the reception stock of the booklets had been exhausted. A booklet was not issued for him and his first night's checks were apparently recorded on a piece of paper.
118. The following morning, the yellow booklet was obtained and the checks recorded in it. However, they appear to have stopped at 12.15pm which is when the last entry was made in the yellow booklet. The man was discovered hanging in his cell at 2.00pm, and it appears that one hour and 45 minutes elapsed between him being seen alive and being found. He should have been checked at about 1.15pm but there is no record in the booklet. The fifth officer who was on duty at lunch time maintains that he did check him at 1.10pm and had no cause for concern. According to the officer's account, he was alive then but the check was simply not recorded in the booklet.
119. The procedures also state that the date, time and location of a prisoner should be recorded every time that responsibility for the prisoner changes. Responsibility for the man was passed back to the staff returning from their lunch break at 1.30pm. Had the booklet been used properly, it is likely that the gap in the record would have been noticed. The staff taking over should have seen that there was no record of check for over an hour. A verbal handover about potential Category A prisoners does not negate the requirement to record the evidence of checks.
120. I have highlighted three areas where the recording of information has been poor. This is concerning, especially as it refers to keeping potential Category A prisoners safe. There was a marker on the PER form that the man was at risk and he was known to be worried about his security

category. Staff should be reminded of their responsibility to make the checks and complete the records.

**The Governor should remind staff of their responsibility to carry out checks and complete the correct documentation for potential Category A prisoners.**

### **Discovery of the man in his cell**

121. I endorse the clinical reviewer's observation that the emergency response was rapid and appropriate. There was no delay removing the ligature or in attempting to resuscitate him. The officers who discovered the man started basic life support immediately. The healthcare response was timely, with assistance arriving within two to three minutes. Resuscitation continued until the arrival of the paramedics, who had been called promptly. Escort staff were identified and he was taken to hospital with the minimum of delay by the paramedics. The clinical reviewer comments that it was appropriate to attempt to resuscitate him as there was no evidence of rigor mortis.

### **First aid training**

122. In previous cases investigated by the Ombudsman, it is often officers and OSGs who discover the prisoner. A number of the officers who went to help the man had been first aid trained in the past but had not undertaken recent refresher training. First aid training for officers is within the remit of the Prison Service and not the Primary Care Trust. The Ombudsman has previously recommended that first aid training should be provided for staff who are in contact with prisoners. I suggest that basic and refresher training is reviewed for all frontline staff at Hewell to ensure that their knowledge of resuscitation procedures is up to date. (I acknowledge that it is unlikely to have made a difference to the man, as healthcare staff arrived promptly.

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

### **Medical equipment**

123. The man was first examined by officers who noticed that he had vomited. Wanting to commence CPR and prevent any delay, the officer used a toilet roll as a face mask and I commend his quick thinking. A proper face mask was provided very quickly. I am aware that there are a number of face masks in the emergency boxes on the house blocks and therefore make no recommendation on this issue. However, from previous investigations, I have learnt that some prison staff carry small emergency face masks on their belts. This has enabled them to start CPR immediately using the right equipment. The Governor may wish to consider the viability of front line staff carrying face masks within their pouches.

124. The defibrillator was brought to house block three by the second nurse as it was not in the emergency “grab bag”. Prison Service Order (PSO) 2700 chapter 11 lists the first line equipment that should be contained in the grab bag and includes an automated defibrillator. Grab bags are kept in two locations within Hewell, one in the outpatient area of the healthcare centre and the other in the treatment room on house block six. It is essential that all necessary equipment is taken immediately to a life threatening situation.

**All emergency equipment should be brought to the scene as soon as a Code Blue call is made.**

125. The investigator and the clinical reviewer visited a number of house blocks to check the availability of emergency response kits required as part of PSO 2700 chapter 11. They found that a number of the kits were incorrectly stocked, with some items missing. Although this had no bearing on the death of the man, they are important issues which the Governor and Head of Healthcare will wish to consider. The Governor has since said that each house block has a first aid kit equipped with two resuscitation face shields and an Emergency Response Kit containing two Merlin CPR masks.

## CONCLUSION

126. The Prisoner Escort Record contained a tick recorded by the police to indicate that the man was at risk of harming himself. No further details were given and none were requested by prison staff. The PER form was read by reception staff who saw that the tick was there. However, no concerns about his well being, any risk of self harm or any mental health problems were identified. He was concerned about his potential Category A status and being unable to make a telephone call. Staff clearly explained the reasoning behind the decision which he appeared to accept. No one identified any signs that he might harm himself.
127. Reviewing the note found in the man's cell after his death, it seems that he had some regret about his past "bad" behaviour. Whether being in prison made him feel that he had let his family and friends down, is not clear. It is clear however that he wanted to inform his family of his whereabouts. He would have preferred to be at HMP Birmingham and being further from home might have increased any feelings of isolation. It seems that, during his extremely short stay at Hewell, his frustration got the better of him and his feeling of hopelessness led to him taking his life.

## **RECOMMENDATIONS**

1. National Offender Management Service should ensure that all Criminal Justice Service agencies who escort prisoners on external movement or transfer from or between prison establishments are using the new style (A4) PER, under the guidance of the new PSO 1025.

**The Prison Service has accepted this recommendation.**

2. The Governor should ensure that any information relating to risk is shared with all staff in reception and the induction unit. In particular staff should be aware of their responsibility to read any significant information relating to risks to a prisoner highlighted on the Prisoner Escort Record (PER) and share this appropriately with colleagues.

**The Prison Service has accepted this recommendation.**

3. The Governor should ensure that all prisoners arriving at Hewell are able to let their next of kin know of their whereabouts, regardless of their category.

**The Prison Service has accepted this recommendation.**

4. The Governor should remind staff from of the importance of providing feedback (written in prison logs) about their contact with prisoners during the induction period.

**The Prison Service has accepted this recommendation.**

5. The Governor should remind staff of their responsibility in completing and maintaining the correct documentation for all potential Category A prisoners.

**The Prison Service has accepted this recommendation.**

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

**The Prison Service has accepted this recommendation in principle.**

7. All emergency equipment should be brought to the scene as soon as a Code Blue call is made.

**The Prison Service has accepted this recommendation.**