Investigation into the circumstances surrounding the death of a man in September 2005 at HMP Manchester

Report by the Prisons and Probation Ombudsman for England and Wales

August 2006

This is the report of an investigation into the circumstances surrounding the death of a man on 22 September 2005. He died, apparently by his own hand, in a cell in the Healthcare Centre at HMP Manchester. He was 38 years of age.

The man was found at 9.50am, by a nurse on duty in the Healthcare Centre, suspended by a bootlace attached to the window bars. The lace had been fashioned into a noose and wrapped tightly around his neck.

A pathologist performed a post mortem examination on 27 September at a hospital in Manchester. The cause of death was identified as: Asphyxia, Hanging. Toxicology was also carried out. The toxicologists opinion was, drugs found within the man's body were consistent with therapeutic dosage and/or post mortem redistribution.

I offer my sincere condolences the man's family and all those touched by his death.

The man had been in prison for just 15 days prior to his death, having been remanded in custody on 7 September by Salford Magistrates' Court when committed for trial at Crown Court. He was to face charges of theft and causing a public nuisance. He had also allegedly told a prisoner who worked in the Healthcare Centre, that he might face more serious charges.

The man was subject to enhanced supervision at the prison as he was known to be at risk of suicide and self harm, having told prison staff that he was thinking of taking his life. The initial stringent conditions of the suicide watch were relaxed the day before he died. During the last of several psychiatric consultations, the man had said that he was less anxious than before, having received positive news about his case at a visit from his solicitor that day. The psychiatrist, who had treated the man regularly, assessed that the conditions could be relaxed but that he should stay on a special watch.

Staff and prisoners at Manchester share a feeling of loss and incomprehension that the man, who to all outward purposes seemed to be in good spirits following news that the charges he faced were less serious than he had at first thought, apparently took his own life.

My investigators visited the man's father at his home. The man's father was close to his son and, although they did not see much of each other, the volume and content of letters his son wrote from prison show the love and respect he had for his father.

Two of my colleagues carried out this investigation on my behalf.

North Manchester Primary Care Trust, carried out a comprehensive clinical review for which I am most grateful

My thanks go also to the Governor and all staff at Manchester.

Every report on a death in custody makes very sad reading. This was a troubled man, but it remains a puzzle why he apparently took his life when he did, and how he obtained the means to do so. However, this is also a report that reflects very well upon both staff and procedures at Manchester prison. There are times when even the best motivated staff and the best designed systems cannot prevent a tragedy from occurring.

I make four recommendations and identify seven areas of good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman **August 2006**

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Summary

1. The man was born in Manchester and he had one brother. His parents had divorced. The man's mother died in August 2005. The charges for which the man was facing trial came about as the result of her death, as amongst other things the man allegedly continued to draw the benefits to which she had been entitled.

2. He enjoyed a normal childhood in the family home and on leaving school started work as a painting and decorating apprentice. He became friendly with people older than himself and he started to take drugs. His life style brought him into conflict with the law, but this was his first time in prison.

3. When he arrived at Manchester, he said he was depressed and withdrawing from heroin. He said also that he was 'hearing voices'. He was located in an induction wing and a suicide prevention and self-harm special care programme was put into place. He said he had been taking unprescribed drugs. Commendably, on the day that he arrived at Manchester, healthcare staff telephoned the Primary Care Trust that had been responsible for his treatment. A member of the PCT gave immediate information in respect of the man's mental illness, and comprehensive documentation arrived next day by fax. He also tested positive for a number of drugs. He was seen by a member of Manchester In reach Mental Healthcare Team and commenced a detoxification course.

4. On 9 September 2005, the man saw a psychiatrist who prescribed treatment. He was not hallucinating at that stage. He remained on the induction wing and a further appointment was made for 14 September. In the event, he was at court that day and the psychiatrist saw him on 15 September. He decided to admit the man as an inpatient in the Healthcare Centre. The suicide prevention management plan continued.

5. The man appeared a bit more settled, but on 19 September he said he was feeling suicidal. He saw the psychiatrist again that day and his medication was modified. It was around that time, probably 20 September, that the man allegedly told a fellow prisoner that he might be facing a murder charge.

6. A further psychiatric appointment was arranged for 21 September. When the man went to his appointment he said he felt much better. He had seen his solicitor earlier in the day and was relieved to find that the charges he faced were not nearly as serious as he had first thought. A nurse who had seen him a day earlier in the Healthcare Centre, was present at the consultation and she said it was like seeing a different person. A weight seemed to have been lifted from him. As a result of the consultation, the psychiatrist decided that while the self-harm supervision should continue, its conditions could be relaxed somewhat. In essence, this meant that the man was not subject to intensive scrutiny. The psychiatrist noted in the ACCT file that he should remain in an anti-ligature cell within the Healthcare Centre. In fact, he was not in an anti-ligature cell, although the psychiatrist clearly thought that he was.

Although there are such cells, they were fully occupied at the time and the man returned to his own cell which had previously been designated 'anti-ligature' but which no longer met new specifications. It is possible that healthcare staff did not see the entry in the file. If they did, they did not act on it as the man returned to his own cell. The psychiatrist also made a note in the man's main medical record to the effect that he was much brighter and did not express suicidal thoughts. He wrote 'Stop intermittent watch' but did not repeat the instruction he had made on the ACCT form in respect of an anti-ligature cell.

7. The standard of this man's medical care was very good. He saw the psychiatrist on four occasions between 8 and 21 September. Records of those consultations are comprehensive. It was apparent also during interview with my investigators that the doctor had a clear understanding and cared deeply for his patient.

Investigation methodology

8. My investigators opened the investigation with an initial visit to HMP Manchester on 27 September. They were briefed by the Governor and Safer Custody Manager. They chaired a meeting and were briefed by staff who were involved with the man. both during his short stay at Manchester and following his death. Police attended the meeting, as did the Vice Chair of the Independent Monitoring Board (IMB) and officials of the Prison Officers' Association. During three follow up visits, 16 members of staff, including the Safer Custody Manager, the Governor, two Chaplains, a member of the Independent Monitoring Board, two doctors, the Healthcare Centre Manager, one prisoner, prison officers and nurses were interviewed individually. All gave their time and information willingly, for which my investigators remain extremely grateful. The Manchester branch of the Prison Officers' Association lent their ready support and facilitated greatly the work of the investigation.

9. Greater Manchester Police shared their information and findings. I am grateful for their cooperation.

10. One of my investigators and one of my Family Liaison Officers met the man's father and brother at their home. They were made most welcome. The information the family provided contributed a great deal to the investigation. The man's father also asked my investigators to place on record his grateful thanks for the compassionate and personal help he had received and continues to receive from the Governor, Chaplains and Healthcare Manager at Manchester. The man's father thought that his son had been treated well at Manchester. However, he wanted to know how his son had acquired the bootlace which was used as a ligature. I have reflected on this, and highlighted his questions, in the body of my report.

11. The North Manchester Primary Care Trust arranged a clinical review of the man's healthcare management at Manchester. The review also made a significant contribution to the investigation.

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HM Prison Manchester

12. Manchester holds prisoners remanded into custody from the Greater Manchester area. The prison was rebuilt following a major disturbance in 1990 and now forms part of the Prison Service's high security estate. At the time of my investigation it held 1245 prisoners.

13. Manchester was market tested, for the second time, in year 2000 and as a result of its success, was awarded a 10 year Service Level Agreement, commencing on 16 October 2001. The Service Level Agreement mirrors the format of commercial contracts held by private prisons. A key principle is that performance delivery carries financial risk.

14. HM Chief Inspector of Prisons, in her report of a July 2004 inspection, said that the prison's arrangements for suicide and self-harm risk were good with all staff alert, aware and properly trained. The safer custody meetings were regular and well-attended by staff, outside representatives and prisoners. Reviews of those at risk were held on time and documentation was of reasonable quality. However, the Chief Inspector's report said that information from reviews did not always find its way into support plans for prisoners. The report noted that anti-bullying arrangements were not good, but this had been recognised by the prison which had appointed a Principal Officer whose work was to bring the anti-bullying strategy and practice to a good standard.

15. There were three apparently self-inflicted deaths at Manchester in 2003, and in 2004 there were six. In November 2004, new systems for staff awareness, together with a comprehensive re-training programme were put into place.

16. Two years after the inspection, Manchester has continued its development and has brought anti-bullying and suicide and self-harm prevention under one umbrella. Further progress has been made and at the time of my investigation, the policy was well-publicised around the prison. Notices on residential notice boards give details of suicide prevention arrangements and how prisoners can contact Listeners (prisoners trained by Samaritans) and Samaritans. The Safer Custody Meeting meets monthly and has a very high profile, being chaired by the Deputy Governor.

17. My investigators found that the Governor and his staff are well-trained, caring and keen to discharge their duties in respect of suicide and self-harm risk. There is a clearly identifiable atmosphere of care and compassion at the prison. My investigators also sensed a clear sense of direction and found active cooperation between staff, prisoners and community groups.

18. In summary, Manchester is a busy and complex local prison. Many of its prisoners have special medical and psychiatric needs and the Healthcare Centre is always fully occupied. It usually has a waiting list for admissions. It is against this backdrop that the prison should be seen.

Events leading up to the man's death

19. This man arrived at Manchester prison on 7 September. He told staff that he was depressed, and that he was withdrawing from heroin, and gave details of his previous medical and psychiatric treatment in the community. Nursing staff in the induction wing in Manchester immediately telephoned Bolton, Salford and Trafford NHS Primary Care Trust (PCT) and spoke to a Criminal Justice Drug Worker, who had personally treated the man as late as 19 August 2005. The prison was given background information in respect of his mental health. The drug worker also agreed to fax notes to Manchester and sent them the following day. Staff at Manchester conducted a risk assessment and located the man in the induction wing, sharing a cell with another prisoner. Reception staff alerted the Healthcare Centre to their anxiety about the man and, although he did not say he had thoughts of harming himself, they considered the warning signals were clear. A special file known as 'Care of at risk prisoners', sub-headed 'Assessment, Care in Custody and Teamwork' (ACCT) was opened. In practical terms, this meant that the man should be observed frequently - three times during the core day and four or five times during the night. A further review was programmed for the next day, 8 September.

20. On 8 September, the man attended an assessment interview under the ACCT programme. During the interview, and in the follow-up action plan, it was noted that he had drug addiction problems and that, although he said he had no intention of self-harming, things could change. The case manager noted that the man was to see a member of the In reach Mental Health Team that day - and later the psychiatrist. A further review was scheduled for one week's time and the ACCT plan remained in place.

21. The man saw a Registered Mental Nurse (RMN) of the Mental Health In-reach Team. The man had tested positive for a number of drugs. The nurse noted that the man said he was hearing voices and that he felt like harming himself and others. She arranged for him to see the psychiatrist, the following day. The criminal justice drugs worker had by now sent records of the man's treatment and history in the community, and a picture of his healthcare considerations was becoming increasingly clear.

22. The psychiatrist saw the man the following day. The psychiatrist noted, in a full record of his assessment, a provisional diagnosis of depression and schizophrenia and he prescribed medication. He also noted that the man said he felt 'ok in the wing as another prisoner is looking after him.' A further appointment was made for 14 September. On 12 September, another RMN saw him and observed him as being more settled and 'much brighter'. She noted that the man was due in court on the 14 September (the day set for a further psychiatric consultation) and rearranged the appointment for the following day. The nurse also spoke by telephone to another member of the PCT, who also had detailed knowledge of the man and learned details of his previous treatment at a nearby hospital. Further clinical records were faxed from the PCT the same day.

23. On 14 September, the man again appeared in court for a pre-trial hearing. The court ordered him to appear for trial at the Crown Court, date not specified, and to be remanded in custody at Manchester until his trial. He returned to his cell in the induction wing of the prison, this time with a new cellmate. An officer spoke to him. The man said he was 'fine' but 'appeared reluctant to engage in conversation'. The officer reminded him of the Listeners arrangements and the Samaritans confidential telephone. At 11.35pm, the man was sitting at his table. Asked if everything was okay, he replied yes. The night passed uneventfully and he appeared to have slept until 7am next morning.

24. The man's psychiatric appointment went ahead as planned on 15 September. The psychiatrist was concerned as the man told him he was hearing voices telling him to kill himself or somebody else. He also said that he had not slept well for a few nights. The psychiatrist admitted the man to the Healthcare Centre as an inpatient and directed an 'intermittent watch'. The second case review under the ACCT arrangements was held the same day. The man attended the review. The case manager noted that this man's care had been taken over within the Healthcare Centre, and that he had thoughts of 'self-harming but has no inclination to carry them out'. The man was seen again later that day by another RMN who completed an assessment and agreed a care plan with him.

25. On 19 September the man was seen by a RMN he had met before. She noted that the man appeared settled and he said he was eating well and sleeping better. In a consultation later that day, the man told the psychiatrist, who had treated him continuously since his arrival at Manchester, that things had not changed much and he was still hearing voices and felt like harming himself. The psychiatrist modified the man's medication and arranged to see him within 48 hours.

26. A fellow prisoner who worked in the Healthcare Centre, told my investigators that the man had said to him, on 20 September, that he might well face a charge of murder in connection with 'someone's' death and that he was worried and uncertain about the way his court proceedings would evolve. He gave no detail of a victim. The prisoner assumed that the man was referring to a crime involving another man.

27. On 21 September the man again saw the psychiatrist. A nurse was present. Both doctor and nurse saw a dramatic change for the better. The man had just returned from a visit with his solicitor. He told the psychiatrist that the charges he faced in connection with the death of his mother were less serious than he had feared. He said he thought the police had been contemplating a charge of murder, but his solicitor had assured him that this was not the case. The psychiatrist noted that the man said he was still hearing voices but did not express any suicidal thoughts. The nurse, who had seen the man a day earlier, told my investigators that it was like seeing a different man. It was as if 'a load had been lightened'. She remembered the psychiatrist asking about self-harm and the man saying he was not feeling suicidal. Later, in interview with my investigators, the psychiatrist said that the change for the better in his patient was the best he had seen in many years of

practising psychiatry. The psychiatrist made a comprehensive note in the man's medical notes to the effect that he was much better. He made a note also in the ACCT file, 'Seen and assessed. Stop intermittent watch. Continue anti-ligature cell.' Both records were returned to the administration office within the Healthcare Centre.

28. It is clear from the psychiatrist note that he thought the man was already located in an anti-ligature cell. However, he was not located in an anti-ligature cell. He returned to his own cell. Moreover, although the psychiatrist made a note on the ACCT form in respect of anti-ligature cell, he did not make one on the main medical record. The Healthcare Manager told my investigator she did not know of the instruction. The cell that the man was located in had previously been designated 'anti-ligature', but no longer met the standard. The anti-ligature cells were fully occupied. It would have been better if entries had been made in the ACCT documentation and in the man's medical record.

The Governor should remind staff of the importance of ensuring that important information is cross-referenced between records and that staff ensure they read all the papers relating to a particular case.

29. Between 7pm on the evening of 21 September and 9am next morning, nine separate entries appear in the mans' ACCT record. The man attended the 'Chaplain's Hour' meeting where he was assessed as sitting quietly at the back of the group but 'does appear to be following proceedings'. At the end of the evening, he appears to have dropped to sleep watching television at 11.50pm and then throughout the night slept in bed. The last entry, at 9am next morning reads 'Status ok. Sat on bed.'

Events following the death

30. At about 9.50am, a nurse started her rounds as was her custom, checking on patients in the Healthcare Centre. She went to the man's cell, looked through the observation panel and saw him hanging from a ligature around his neck, attached to the cell bars. The nurse does not carry a cell key, but the office was immediately opposite the man's cell and she went in, calling for assistance. The senior healthcare officer was working in there and together they went into the man's cell. They called for further assistance. A RMN on duty pressed the alarm bell. Manchester's emergency plan was activated and the incident log provides a detailed timetable of subsequent events. An ambulance was called at 9.56am. The nurse was sent for the 'suicide box'. At 9.55am, an officer who was by that time in the cell, assisted the senior healthcare officer and nurse to cut the ligature, a black bootlace, and they started resuscitation procedures. Despite using two sets of protective mouth equipment, the nurse had to break off twice to clean out her own mouth. The on call doctor for the prison arrived at 10am and the team continued to try to revive the man. They established an airway and noted the defibrillator instruction not to apply shock treatment but to continue with resuscitation.

The nurse should be commended by the Governor. She was distressed as she knew the man and thought he was over the worst. Nevertheless she performed superbly well in her response to these sad events and particularly in the resuscitation process. The work was difficult and unpleasant but she had no regard for herself. This was commitment of the highest order, in the best traditions of the Prison Service.

31. Paramedics arrived at the prison at 10.05am and the prison doctor, in consultation with them, pronounced the man dead at 10.09am. In accordance with emergency procedures, the man's cell was sealed to await the arrival of the coroner's officer and police.

32. The duty chaplain, was paged at 10am and he also went to the man's cell. He was there within a few minutes, but by that time the man was dead. At 12 midday, the Healthcare Centre Manager, a police officer, and chaplain visited the man's father at his home. Together they broke the news. The chaplain and his colleague accompanied the man's father that evening to the infirmary in order that he might formally identify his son's body. In five or six further visits and telephone calls, the chaplains helped the father to make arrangements for his son's funeral. They gave him a letter of sympathy from the Governor and they paid funeral expenses on his behalf. Some days later they conducted the funeral service at the family's request. All of the man's family remain deeply grateful to them for the care and support which they continue to receive from the chaplains.

33. On the same day this man died, a governor grade conducted a review meeting. This was in order to establish whether or not they had done all they could and to examine, while things were fresh in their minds, if there were lessons to be learnt. Sixteen

members of staff attended, including two members of the Care Team. The notes are clear, concise and an example of good practice within the Prison Service. Care Team members subsequently contacted all staff who had been involved in the sad circumstances of this death.

Clinical review

34. In the clinical review completed on 2 November 2005, it was found that the man's contacts with individual clinicians at HMP Manchester were timely and well documented, and that he had cooperated fully with his assessments and treatment. Such variations as were made to his medication were possible because he was honest throughout in respect of the way he was feeling. Consequently, nurses and doctors made all decisions with regard to the information available at each consultation and as a result of observing the man as an inpatient in the Healthcare Centre.

35. The clinical reviewer observed, 'There was nothing to indicate at the last psychiatrist's review that the man was going to take his own life.' The review found that resuscitation procedures were conducted appropriately by staff and she noted that they were supervised between 10am and 10.09am by the prison doctor.

36. Finally, the review recommended that reviews and decisions in respect of patients subject to suicide and self-harm procedures should be taken by the multi-disciplinary team and not an individual clinician. The decision to stop the man's 'intermittent watch' was taken by the psychiatrist alone on the 21 September.

Decisions to vary the conditions of a suicide and self-harm programme under ACCT should be taken by the full review team.

37. The review noted one example of good practice: 'The lead nurse for Dual Diagnosis and the RMN on duty at the time of the man's admission can be complimented for their comprehensive and clearly written records.'

The RMN and RGN should be commended by the Governor and Senior Medical Officer for the high quality, clarity and comprehensive recording of their contributions to the man's care.

Conclusions

38. The man was mentally ill for many years before being sent to prison for the first time on 7 September. He was bound to find prison life difficult and the circumstances in which he was sent there were highly unusual. He was charged with offences, in themselves serious enough. But at the time of his remand into custody, there was the possibility in his own mind that even more serious charges were being considered.

39. Reception and induction staff at Manchester carefully and accurately assessed his condition. In a commendable display of teamwork, the discipline and healthcare professionals in prison and in the community identified his needs and ensured they were met. Manchester staff contacted healthcare workers who knew him in the community and put in place a comprehensive management plan to help him through his early days in prison. He went into a shared cell with someone he knew, and risk assessments and actions arising from them were complete and accurate. Within a day or so, written details of previous diagnoses and treatments arrived from the PCT, and within five days a comprehensive psychiatric history was also to hand.

40. The medical and nursing care provided for the man was excellent. In the fortnight he was in Manchester, he was assessed formally on four occasions by the same psychiatrist, and was interviewed and counselled on at least as many occasions by skilled healthcare professionals. Discipline staff played their part and their entries in self-harm documentation were full and well-observed. The standard of care within the main induction centre and in the healthcare centre is considered to have been excellent.

41. While the decision by the psychiatrist to discontinue the intermittent watch on the man does not appear justified by subsequent events, given the nature of his last consultation with him (and the evidence of the nurse, it seems likely that a multi-disciplinary review panel would have come to the same conclusion.

42. It is regrettable that the instruction in respect of the psychiatrists implicit belief that the man was in an anti-ligature cell, an arrangement which he said should continue, was not cross-referenced from the ACCT form to the medical record. The Healthcare Centre Manager told my investigator that she did not know of the instruction. In any case, the anti-ligature cells were occupied by prisoners who had greater needs. Nevertheless, the instruction should have been clear in both records.

43. The day before he died, the man wrote to his father, saying ‘I am not too good at the moment, the psychiatrist has increased my medication but don’t worry, I’ll bounce back.’ He went on to say that he was to see his solicitor that day (the visit after which he told the psychiatrist about that serious charges against him were not to be pursued) and that he was looking forward to a ‘canteen pack’ (food, tobacco, sweets etc). He ended the letter by saying, ‘Please write to me soon. I’ll look forward to hearing from you.’ Given the tone of that letter and the later news from his solicitor, it

seems reasonable to believe that he, if not on top form, was coping well enough given the circumstances in which he found himself.

44. It has not been possible to establish how the man acquired the bootlace. Police searched the cells adjacent to the one in which the man died and found no evidence of his having acquired it from within that area. My investigator examined Manchester's Service Level Agreement in respect of searching requirements. All targets had been met, including, significantly, those relating to the Healthcare Centre. It is known that the man had asked for a change of clothes shortly before he died. He may have changed his clothes or he may not. Records of such routine matters are not kept. In any case, the healthcare store holds only basic items of clothing and laces are not kept there.

Recommendations

1. **The Governor should remind staff of the importance of ensuring that important information is cross-referenced between records and that staff ensure they read all the papers relating to a particular case.**

2. **The nurse administering CPR should be commended by the Governor. She was distressed as she knew the man and thought he was over the worst. Nevertheless she performed superbly well in her response to these sad events and particularly in the resuscitation process. The work was difficult and unpleasant but she had no regard for herself. This was commitment of the highest order, in the best traditions of the Prison Service.**

3. **Decisions to vary the conditions of a suicide and self-harm programme under ACCT should be taken by the full review team.**

4. **The two RMN should be commended by the Governor and Senior Medical Officer for the high quality, clarity and comprehensive recording of their contributions to the man's care.**

Good practice

1. **Cooperation between prison and PCT was excellent. Oral and documented information was comprehensive and conducted quickly and without fuss. This is clear evidence of a true partnership between services.**

2. **Record keeping at Manchester was excellent at all levels with staff sharing information willingly. Notes were full, comprehensive and provide evidence of good training and understanding of the importance of good documentation.**

3. **Co-operation between Manchester prison and Greater Manchester Police was excellent. Documents were freely exchanged and my investigators had access to all they required. Police, during their formal interviews, asked each person interviewed to indicate if they agreed to release to my investigators records of their interview notes. All agreed and the documents were released at our first visit.**

4. **The post-incident de-brief was held immediately. It was well chaired by a governor grade it was well attended and comprehensively minuted. The notes of the meeting were used to review and improve Manchester's contingency plans.**

5. **Manchester's care team saw all staff involved. They systematically and purposefully made sure that those who needed help received it and that others were coping with their shock and sense of loss at the death.**

6. **The two Chaplains performed their tasks to a standard well above and beyond the call of duty. The support they gave to the man's father and his family, the conduit they provided between him and the prison and their eventual conducting of the man's funeral service are together evidence of commitment of the highest order.**

7. **The Chaplains, The Healthcare Manager, and Detective Chief Inspector of Greater Manchester Police, are to be congratulated on the sensitive way in which they worked together to bring sad news of the death to the man's father when they visited him at his home.**