Investigation into the circumstances surrounding the death of a man at HMP Manchester on 4 September 2004

Prisons and Probation Ombudsman for England and Wales
December 2005

This is the report of an investigation into the death of a man at HMP Manchester on 4 September 2004. The circumstances in which he died were very rare. Both he and his cell-mate were found hanging in their shared cell.

I wish to offer my sincere condolences to the family and friends of this man for their tragic loss. I know the staff and prisoners at Manchester who knew him share those sentiments.

I am grateful to my Deputy Ombudsman for leading this investigation. She was assisted by one of my Assistant Ombudsmen, and a colleague from HMP Whitemoor. I also wish to extend my thanks to the Governor of Manchester and his staff for their help and co-operation during this investigation.

There is necessarily some overlap in content, findings and conclusions between this report and the one following the death of the man's cell-mate.

Stephen Shaw CBE
Prisons and Probation Ombudsman **December 2005**

SUMMARY

1 The man at the centre of this report was 28 years old when he died at his own hand in HMP Manchester.

2 In February 2004 he was charged with robbery and remanded into custody at Manchester. This was not his first time in prison. He had served a number of periods of imprisonment, mainly for offences related to his misuse of drugs. His convictions dated back to 1987.

3 On reception into prison, the man stated that he was misusing amphetamines and cannabis. He also said he was drinking heavily, and he was clearly suffering the physical effects of withdrawal. He said that he had suffered mental health problems, but denied any suicidal tendencies. He said he had not complied with treatment for the previous nine months because it "clashed" with his drinking.

4 On 6 February, discipline staff alerted health care to the man's mental health state and he was assessed by the mental health in-reach team and admitted to healthcare. His behaviour over the next two months was, at times, impulsive and unpredictable. He was identified as having a personality disorder with anti-social behaviour.

5 On 11 April the man was considered fit to return to normal location. He requested vulnerable prisoner status, which was granted. On 14 April, he transferred to a single cell on A wing. He appeared to have a settled for a few weeks and gained employment as a wing cleaner. However, by the middle of May, he asked to restart his medication as he thought it would help him cope with his impending trial. At the beginning of June, the man referred himself to the community psychiatric team. He also began attending the day care centre on an *ad hoc* basis, as he found the atmosphere therapeutic and it enabled him to relax.

6 On 1 July, the man said that the day centre enabled him to cope on the wing. However, a week later his forthcoming court case was causing him to feel vulnerable and unable to cope adequately on the wing. He denied any thoughts of self-harm or harming others.

7 On 24 August, the man moved cells to share with another prisoner. By 30 August, the two men expressed concerns about their personal safety and on 1 September they refused to return to their cell. After discussions with staff, they did go back peacefully and matters appeared to settle down. There were no further reports of concerns about their safety.

8 At 6:47 am on 4 September, the man and his cell-mate were found hanging in their cell. Both men left a suicide note.

9 During the investigation, Manchester's standards of record keeping were found to be less than adequate. It was also discovered that the night patrol officer had undertaken the head count between 2:30 am and 3:00 am, by his own admission, rather than at the required time of 6:00 am. This will have undoubtedly delayed the discovery of the two men.

10 Nothing I have seen has suggested that the actions of the two men could have been predicted or directly prevented. I am reproducing in the report the seven recommendations I have made in the report into the death of the man's cell-mate.

BACKGROUND

The Man

11 This man was born in Barnsley, Yorkshire. He described his childhood as traumatic and lacking emotional support.

12 His first offence occurred at the age of 11 when he stole a bag of frozen chips for the family evening meal. By the age of 13, he was placed in a care home and spent the next couple of years in the home or in young offender institutions.

13 The man described his life as chaotic, due to misusing drugs and periods of imprisonment. He had a significant number of previous convictions and had no sustained periods of employment.

14 In November 2003, the man was charged with two counts of criminal damage and one of harassment. He was remanded into HMP Doncaster on 3 December 2003, and was subsequently bailed, following a video link court appearance, on 9 December 2003.

15 On 3 February 2004, he was charged with robbery at Manchester City Magistrates' Court and remanded into custody, having been refused bail. He was taken to HMP Manchester where he arrived some time during that afternoon.

HMP Manchester

16 HMP Manchester is a core local establishment managed under a Service Level Agreement. Its Mission Statement aspires to provide a safe, secure and purposeful environment.

THE INVESTIGATION PROCESS

16 The investigation was conducted by my Deputy Ombudsman and one of my Assistant Ombudsmen, supported by a colleague from HMP Whitemoor. This high-level team reflected the highly unusual circumstance of a double apparent suicide.

17 The Governor and his staff produced well presented files containing all the relevant documents and policies.

18 The investigation team met with representatives of the Prison Officers' Association and Independent Monitoring Board and informed them of the scope of the investigation.

19 Documents pertaining to the man's time in custody were examined and prison staff interviewed. A large number of police witness statements and evidence was also made available for examination.

20 Following the discovery of the man and his cell-mate, a full police investigation was opened. Following extensive forensic examination, it was decided that there were no suspicious circumstances or third party involvement and so the police closed their file.

CUSTODIAL HISTORY

21 The man was remanded into custody on 3 February 2004 charged with robbery. The alleged offence was committed whilst he was already on bail for two counts of criminal damage and one of harassment.

22 At reception, he was seen by healthcare staff and a nurse assessed him using the modified first reception health screen. The man stated that he had recently been homeless and had been misusing amphetamines and cannabis. He denied the use of any other illicit substances. He also admitted to the heavy use of alcohol: up to six litres of cider per day. He said he had no concerns about his physical health, but was worried about withdrawing from drugs and alcohol.

23 When asked about his mental health, the man said that he had previously been treated by a psychiatrist for what he described as 'mild schizophrenia'. He said that he had not complied with the treatment for the previous nine months. He denied any previous self-harm or current suicidal ideation.

24 A further physical examination of the man identified that he was suffering from the physical effects of withdrawal. He was prescribed a chlordiazepoxide detoxification and a request was made for follow up by the alcohol team.

25 The man was located on G wing and no risks from sharing a cell were identified. The Cell Sharing Risk Assessment (CSRA) was appropriately completed during the reception process and by the locating officer. The man was issued with the relevant first night induction literature on his arrival on the wing.

26 On 6 February, prison officers on G wing made contact with healthcare after the man contacted them, saying that he was having mental health problems. He was seen by one of the Mental Health In-Reach Team, who noted that he was anxious and agitated. He expressed thoughts of seriously assaulting fellow prisoners, and also stated that he was hearing voices and experiencing paranoid ideas. During the interview, the man provided further information about the psychiatric medication he had previously been prescribed. He had stopped complying with his treatment because it "clashed" with his drinking. At the end of the interview, a staff nurse referred the man to the healthcare inpatients unit for a period of assessment. The staff nurse also planned to follow up his past medical history by contacting the man's former psychiatric consultant.

27 Later that day, following the referral by the mental health in-reach team, the man was reviewed by a doctor. The doctor's initial impression was that he had a personality disorder. The man was assessed as suitable for a single

cell and was prescribed sleeping tablets for 14 days. The doctor requested that his mental state should be observed.

28 The doctor reviewed the man again three days later, and the man told him that the medication (Zopiclone) was not helping him to sleep. He told the doctor that he "felt like battering somebody". The doctor maintained his initial diagnosis, with the additional description of anti-social behaviour. The absence of nursing notes, care plan or entries in the man's history sheet, suggests that no action was taken to review the CSRA in the light of this information.

29 The doctor reviewed his patient again on 10 February and assessed him as suitable for location in either a single or shared cell. The doctor noted in the medical record that there was no evidence of mental illness and maintained the personality disorder diagnosis with anti-social behaviour. Care plan progress notes were commenced following this review but, as an initial care plan had not been drawn up, there was nothing to measure the man's progress against.

30 Following the ward round on 12 February, the entry in the medical record once more refers to the need to request the previous notes from Doncaster. The following day the medical record notes that the Zopiclone was stopped, but it is not clear why this happened.

31 The nursing progress notes for the next two weeks indicate that the man settled on the unit, behaved appropriately and interacted with staff. On 17 February, his CSRA was reviewed, in accordance with the local policy. He was appropriately reassessed as medium risk reflecting that at the time he was settled, but regular reviews and monitoring of his situation were required because of his unpredictability.

32 The doctor saw the man again on 26 February. The man did not refer to hearing voices but did state, "I irritate myself sometimes, I could kill somebody without remorse". There is no evidence that this statement was explored further or that it was passed on to the nursing staff. The doctor maintained his diagnosis of anti-social personality disorder, but also documented that he considered the man to have an impulsive personality. Following discussion with another doctor on the ward round, it was considered appropriate to prescribe mood stabilisers, namely Olanzapine and Citalopram.

33 Over the next week, the nursing notes indicate that the man was settled and co-operated with the regime and interacted positively with others.

34 During the evening of 7 March, he set fire to his rubbish bin and a pile of papers under the lower bunk. His cell-mate was in the cell with him at the time. The emergency services attended and no major damage was caused.

Thanks to the prompt action by staff, neither the man nor his cell-mate suffered any serious injuries. Following the incident, the CSRA was promptly reviewed and the man was identified as being high risk. A self-harm at risk form was raised, and remained open until 26 March.

35 The doctor reviewed the man after the cell fire and again requested that his previous medical record from Doncaster be obtained.

36 On 10 March, the man asked to remain in his cell as he said he was likely to do "something" to another prisoner. On further questioning, he informed staff that he was convinced one of the prisoners on the unit had abused him as a young boy. The following day, he was taken out of the prison for questioning by police about the allegations and he remained in their custody for two days.

37 For the next two weeks, the man appeared settled, interacting well with staff and prisoners. Staff considered that his mental state was stable and he was functioning well on the unit. His mental state was noted to have deteriorated on 22 March. He was said to be inappropriate in his actions and had become disruptive in education. The previous day, the man had written a letter which he passed to staff. In the letter, he reflected on the alleged abuse he suffered as a child and described his mission "to destroy most human beings". A request was made that the man be reviewed by the medical officer.

38 The man was seen again by his doctor on 25 March, and the dose of Citalopram was increased. The doctor's record also recommended consideration of a transfer back to the residential units. Once again, entries in the medical record refer to the need to obtain the man's previous medical records. Entries in the nursing records reflect that the man had no insight into his behaviour in education, resulting in his exclusion from the class.

39 On 5 April, the man was seen by the doctor after a fight with another prisoner the previous day. When he was asked why he had behaved in this way, he replied that he "did it because I liked to do it". The doctor considered that he was fit to share a cell, despite the events of the previous weeks, and once more noted that the man should be considered for transfer to ordinary location. The doctor also documented that the man was fit for an adjudication resulting from the altercation with the other prisoner. The man was adjudicated on later that day and the charge was proven, following his guilty plea. His punishment was suspended for three months.

40 Three days later, on 8 April, the man was again involved in a fight with another prisoner. He declined to see the medical officer, despite two scratches to his face. He was placed on report and was adjudicated on two days later. The charge was proven and he was punished with 14 days loss of association, in-cell electricity, recreational PE and 50% stoppage of earnings. His previous

punishment, suspended for three months, was also activated to run concurrently.

41 On 11 April, the man requested vulnerable prisoner (VP) status. Discussion with management occurred, particularly regarding information that the man had "major problems" with vulnerable prisoners. It was appropriately decided that he should be given his own protection, but not full VP status, and should be transferred to A wing. He was discharged from healthcare on 13 April and relocated in the segregation unit, to await a bed on the wing. On 14 April, a bed became available and he transferred from the segregation unit to a single cell on A wing.

42 On 18 April, the man was interviewed regarding the possibility of a cell-mate. He said that he had no problems with anybody, as long as they were not sex offenders, and he was noted to be polite during this interview.

43 It appears that the next four weeks were uneventful, as there are no entries in his history sheet or medical record to suggest otherwise. Entries on the man's prescription chart indicate that, on occasions, he refused to take his medication. Given the absence of entries in the records, it is not known whether non-compliance with medication had an adverse affect on his mental health.

44 On 12 May, the man began work as a wing cleaner.

45 He was seen by healthcare on 27 May, because he was not complying with his treatment. The doctor noted that the man said he had "lots going on", his trial was coming up and he felt he had little support from his family; he also asked to resume the Citalopram to prevent "stresses" worsening his mental state. The doctor therefore restarted his Citalopram at a dose of 20mg, once daily.

46 The mental health in-reach team reviewed the man on 11 June, following a self-referral. Speaking to a Community Psychiatric Nurse (CPN), the man expressed his anxieties which related to a forthcoming court appearance as a prosecution witness regarding the childhood sexual abuse. The CPN offered him support and reassurance, and contacted Witness Support Services to discuss the support that would be available to him whilst he was in prison.

47 After a request from wing staff, the man attended the day care centre on 16 June. He had a one-to-one counselling session, which enabled him to express his concerns and anxieties. He said that he found it useful. He attended the centre the following day, and found the atmosphere therapeutic and relaxing.

48 On the afternoon of 22 June, the CPN saw the man on the wing. She said that he felt angry and was struggling to control himself. The next day he attended the self-harm support group, and on 30 June, he attended the day centre again for support. On 1 July, the man stated that he was coping on the wing through the support of the day care centre.

49 The CPN reviewed the man on the wing on 7 July. She said that he was finding it increasingly difficult to cope, and he was worried about the impending court case. He denied any thoughts of self-harm or suicide, and said he had no thoughts of harming others, and would seek help if things were became too much for him to cope with.

50 Over the next month, the man continued to attend the day care centre occasionally and received regular support from the mental health in-reach team. The medical records noted that a number of the mental health interventions were requested by wing staff. However, the wing history sheet gives no indication of any concerns about the man's mental health, and there are no entries of any significance between 18 April and 15 August.

51 On 24 August, the man moved cells to cell A2-105 where he gained a cell-mate. On 27 August, he attended court, expecting to be released. However, he returned to the prison that afternoon having been sentenced to four years imprisonment. His sentence calculation was carried out and the parole eligibility date was calculated as 1 February 2006, and the non-parole date was 2 October 2006.

52 On 29 August, an entry in the wing observation book notes that the man and his cell-mate had allegedly received threats from the main prison. They were seen by an officer who offered support and advised other staff to be alert to potential incidents. From the information given by the man and his cell-mate, it became clear there was a complicated relationship between them and another prisoner, who they perceived was behind the threats. They were anxious about what he might do and expressed concerns about their personal safety.

53 This information was followed up with the completion and submission of a Security Information Report. This was assessed by the security manager on 31 August. The security manager notes,

'Wing managers of A and C wing to be made aware contents of this report. Staff to be fully briefed regarding possibility of repercussions involving these prisoners. Document in history sheet to keep separate.'

The history sheet does not reflect this information or the actions recommended by the security manager and subsequently endorsed by the

security governor. This was not the first time that security intelligence and the subsequent proposed actions were not reflected in the history sheet.

54 The following week, on 30 August, the man passed a note under his cell door indicating that he and his cell-mate believed that their lives were in danger from another prisoner. They were interviewed the next day about their concerns and the man said that he believed there was a "large price on his head".

55 From the information given by the two men, it became clear that there was a complicated relationship web between them and the other prisoner: the cell-mate was in debt to him because he had purchased drugs, and the man's sister had been in a long term relationship with the other prisoner, who had been arrested and charged with murder. The sister and her children gave evidence against this other prisoner, resulting in his conviction. The man and his cell-mate clearly had anxieties about the potential threat posed by him, and expressed concerns about their personal safety.

56 On 1 September, both men refused to return to their cell when the association period came to an end. A Principal Officer spoke to them and persuaded them to return to their cells. The entry in the history sheet gives no insight into the reasons behind their initial refusal to return to their cell or any advice or support that was offered at the time.

57 The man was subsequently interviewed about the incident by an officer on 3 September and advised of the sort of behaviour that was expected of him as a peer group leader.

DISCOVERY OF THE DEATHS

58 On 4 September, an officer carried out the morning roll check. He started on the outer part of A wing and worked his way up the landings, before crossing to the inner part where he started on the fours landing and worked down. He got to cell A2-105 at 6:48 am and looked through the observation hatch where he saw the two prisoners. He thought that they were standing up, one facing the window and the other facing the door. Despite the dim light, he was able to see that the man and his cell-mate were hanging with ligatures around their necks. The officer immediately put out a radio call for assistance and ran to pick up the suicide box.

59 When he tried to open the cell door, the officer found that it was blocked and he had to kick it several times to gain entry. It had been blocked with the wardrobe unit. He then entered the cell, together with three other officers, who had responded to the urgent message.

60 The four staff began to take the men's weight and remove the ligatures, which was more difficult because the space was limited and both men had oil on their feet which made them slippery. By the time the ligatures were removed, healthcare staff had arrived at the cell. The staff withdrew from the cell to make space for the healthcare staff to work. Two nurses immediately assessed the situation. It was evident from the condition of the men that they had both been dead for some time. They decided not to attempt resuscitation. This was the correct judgement.

61 An ambulance with paramedics arrived at the prison at 7:01 am. They were quickly escorted to the wing where they entered the cell. They noted that both bodies were cold to the touch and their pupils were fixed and dilated. The first paramedic attached a defibrillator initially to the man, and then to his cell-mate, but there was no cardiac output from either. The paramedics could do nothing more to assist and so left the cell.

62 A doctor attended at 10:35 am and certified the deaths of both men.

ACTIONS AFTER THE DISCOVERY OF THE TWO MEN

63 The control room log states that the deaths were discovered at 6:47am, and all available staff were asked to attend A wing. The ambulance service was contacted at 6:51am. One ambulance arrived at 7:01am, and a second arrived two minutes later. At 7:08am, it was evident that two ambulances were unnecessary and so the second left the prison.

64 The police were contacted at 7:19am and arrived at the prison at 7:43am. They were escorted to A wing and taken to the cell, where they noted that it was locked and secure. A prison officer was located outside the cell to act as a log keeper.

65 A governor arrived at the prison when the message requesting immediate medical assistance came over the radio. At the same time, a nurse also arrived for work. She hastened her progress through the staff search and, along with the gate Senior Officer, all three made their way to the wing. This governor was satisfied that everything was being well managed and he went to the control room to activate the contingency plan.

66 The governing Governor, the Duty Governor, the Care Team, Independent Monitoring Board and Chaplaincy were all notified of the events. When the governing Governor and Deputy Governor arrived at the prison, they were briefed by the first governor to arrive at the prison.

67 The duty governor and the chaplain were asked to visit the families of both men, after the chaplain had first contacted them by telephone and informed them of the tragic events of the morning. Because of concerns expressed by the police, there was considerable delay leaving Manchester to travel to the man's family home in Barnsley. On arriving in Barnsley, the duty governor, the chaplain, and two Family Liaison Officers (FLOs) went with local police to visit the man's family.

68 Events at the prison continued and there were significant numbers of police in attendance to assess whether there was any indication of foul play. The police are satisfied that there is no suggestion or evidence of any suspicious circumstances.

69 An Operational Support Grade (OSG) had been the night patrol on duty during the night of 3/4 September and had carried out a roll check on the morning that the men were discovered. He went off duty by the time that they were discovered, and at 7:40am a message was left on his mobile phone at a governor's request. At 7:57am, the OSG contacted the prison to inform them that he was returning. He arrived at 8:25am and made a statement to the governor and a witness statement to the police.

70 The residential night patrol orders require the night patrol to conduct a full wing roll check at 6:00am and report the figures to the Night Orderly Officer. The OSG said that he had carried out the check between 2:30am and 3:00am on 4 September and no further checks were carried out. The Governor immediately commissioned an internal disciplinary investigation, which has now concluded.

FINDINGS AND CONCLUSIONS

71 I have uncovered no evidence that the actions of the man or his cell mate could have been predicted, or therefore directly prevented, by prison staff.

72 On reception into custody the man stated that he suffered from mental health problems, but denied any suicidal tendencies. He also disclosed that he misused drugs and was drinking heavily.

73 The man's behaviour was at times unpredictable and impulsive. He was diagnosed as suffering from a personality disorder with anti-social behaviour, following a period of assessment in the health care centre. He returned to ordinary location and was supported by the mental health in-reach team. The man also began attending the day care centre which he found therapeutic. Despite the intervention from the mental health team there are limited entries in his wing records giving an indication of the types of interventions and the support offered to him.

74 Whilst in healthcare the man expressed concerns about his potential for violent behaviour towards others. It is not evident that this was communicated to other healthcare staff or member of the multi-disciplinary team involved with his care. Cell sharing risk assessments were not always reviewed, Security Information Reports were not completed, history sheets not completed and care plans not drawn up.

Healthcare staff should be reminded of the need to communicate effectively with other members of the multi-disciplinary team through the completion of security information reports, cell sharing risk assessments and history sheets.

75 The wing observation sheet contains no entries of any significance between 18 April and 15 August, despite numerous interventions by the mental health team. It is essential that all staff involved in prisoner care make contemporaneous records to ensure continuity of care and good communication amongst the multi-disciplinary team. Furthermore, following the incident when the two men refused to return to their cell, on 1 September, the entry is brief and gives little insight into the reasons for the refusal or any support or advice offered to them both.

Staff should be reminded of the need for appropriate, accurate and contemporaneous records to protect the welfare of prisoners and enable appropriate management.

76 A number of Security Information Reports were submitted for the man. Whilst the report is appropriately completed, assessed and action plans developed, there is no documented evidence to support the action points having been

followed up or communicated effectively to other members of the multi-disciplinary team.

A review of the SIR action and follow-up procedures should be undertaken to ensure that there is an auditable record of compliance with follow-up action points and the outcome of such actions.

77 The F80, Report of Locking Up, did not show times that roll checks took place. Furthermore, the night patrol undertook the 6:00am head count several hours earlier than required and no more checks were carried out. The matter was commendably identified by the Governor and an immediate internal investigation was commissioned.

A review of the local procedures for completing the F80 should be undertaken to include the requirement to state clearly the times of roll checks and observations of prisoners as required.

All night staff should be reminded of their roles and responsibilities during the night patrol period.

78 There is clear evidence of appropriate levels of support for staff directly involved in the tragic deaths of the two men. However, other staff working on the wing (not on duty at the time, were not offered support), although they too felt involved with the deaths from their normal day to day knowledge of the men. Staff should be reminded how they can access care and support services.

Governors should be reminded to extend post incident support/care arrangements to all staff, and ensure that all staff involved with prisoners are afforded appropriate care and support.

RECOMMENDATIONS

1. Governors should be reminded to extend post incident support/care arrangements to all staff, and ensure that all staff involved with prisoners are afforded appropriate care and support.

2. A review of the SIR action and follow-up procedures should be undertaken to ensure that there is an auditable record of compliance with follow-up action points and the outcome of such actions.

3. Staff should be reminded of the need for appropriate, accurate and contemporaneous records to protect the welfare of prisoners and enable appropriate management.

4. A review of the local procedures for completing the F80 should be undertaken to include the requirement to state clearly the times of roll checks and observations of prisoners as required.

5. All night staff should be reminded of their roles and responsibilities during the night patrol period.

6. Healthcare staff should be reminded of the need to communicate effectively with other members of the multi-disciplinary team through the completion of security information reports, cell sharing risk assessments and history sheets.