# Investigation into the circumstances surrounding the death of a man at HMP Manchester in 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 the man 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 the 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 the Assistant Ombudsman. 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** **December 2005**
**Prisons and Probation Ombudsman**

## SUMMARY

1 The man who died was 32 years old when he took his own life whilst in prison custody at HMP Manchester. He had convictions dating back to 1987 when he was 15 years old and attributed his offences to misusing drugs. The man had received a variety of punishments from the courts, including custodial sentences.

2 In March 2003, the man was remanded in custody to HMP Durham. He was charged with robbery and possession of firearm (imitation), offences committed a year earlier.

3 Two days after his reception at Durham, the man took an overdose of prescribed diazepam. A Self-harm at Risk form (F2052SH) was opened. A multi-disciplinary review took the decision to close the F2052SH on 30 March 2003. Later the same day, he transferred to Leeds at his request as it made visits easier for his family.

4 On 22 December, the man was sentenced to life imprisonment with a tariff of two years eight months. This meant he would have been eligible for release on licence from August 2006 onwards. The post conviction immediate needs assessment was not completed for over three weeks. Furthermore, he was not seen for his post-conviction induction interview until the end of March 2004.

5 The man transferred to HMP Dovegate in April 2004. On 19 May, he lacerated his left wrist and was admitted to healthcare for assessment. Whilst at Dovegate, he admitted to using heroin and having got himself into debt with other prisoners.

6 In mid-June, the man transferred to Manchester to make a new start. However, his drug debt followed him and in August he requested vulnerable prisoner (VP) status for his own protection. The man moved into the cell with another Prisoner on 28 August. On 1 September, the man and his cell-mate refused to go back into their cell, and expressed concerns about their personal safety. After discussion with staff, they did return to their cell and apparently settled down.

7 Three days later at 6:47 a.m. on 4 September, the man and his cell-mate were discovered hanging in their cell. A suicide note was found in the cell in which the man apologised to his family for all he had put them through. His cell-mate had also left a 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 man and his cell mate.

10 Nothing I have seen has suggested that the actions of the two men could have been predicted or directly prevented. The report makes seven recommendations.

## BACKGROUND

### *The Man*

10 The man who died was born in August 1972, in Huddersfield, Yorkshire, the third of five children. When he was seven years old, his mother was unwell and so he was placed into the care of the local authority. The man attended school regularly, but left without any formal qualifications.

11 After leaving care, the man described his lifestyle as unsettled. He began to misuse substances during this time. Initially, this involved glue sniffing. He subsequently misused illicit drugs such as ecstasy and amphetamines, before finally falling prey to heroin and crack cocaine. Misuse of substances resulted in him appearing before the courts and receiving custodial sentences. The sentences, coupled with misuse of drugs and his unsettled life-style, meant that the man was unable to sustain regular or long term employment.

12 During the mid 1990s, the man was in a stable relationship for about two years and had a daughter with whom he maintained regular contact. At the time of this conviction, he told the authorities that he still maintained an amicable relationship with his ex-partner.

13 The offences of robbery and possession of an imitation firearm with intent were motivated by the need to fund his drug habit and to repay a drug related debt.

### *HMP Manchester*

14 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

11 The investigation was conducted my Deputy Ombudsman and Assistant Ombudsman. This high-level team reflected the highly unusual circumstance of a double apparent suicide.

12 The Governor of HMP Manchester and his staff produced well presented files containing all the relevant documents and policies.

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

14 Documents pertaining to the man's cell-mate time in custody were examined and prison staff interviewed.

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

## CUSTODIAL HISTORY

19 The man committed the offences for which he was charged in February 2002, but was not remanded into custody until March 2003. He was initially received at HMP Durham on 17 March.

20 On reception at Durham, he was seen by a healthcare worker and an initial health assessment was undertaken. The man advised the healthcare worker that he was seeing his General Practitioner due to his substance misuse, and was receiving diazepam and subutex for the management of his withdrawal. He had no other concerns about his physical health.

21 When asked about his mental health, the man told the interviewer that he was being seen by a psychiatrist as a result of childhood abuse. He also informed them that he had previously received Prozac. There is no indication that he was still on that medication at the time of his reception. He stated that he had never previously self-harmed and did not feel suicidal at that time. However, a subsequent pre-sentence report states, *"Previous reports indicate there have been previous instances of self-harm."*

22 The man indicated that he would like to see a doctor, specifically in relation to withdrawal from illicit substances. He was seen by the duty medical officer who carried out a physical examination, which included obtaining base-line observations of his temperature, pulse, breathing and blood pressure. He was offered and accepted a detoxification programme using lofexidine.

23 A Cell Sharing Risk Assessment (CSRA) was carried out in accordance with national policy. It did not identify any concerns and the man was considered to be low risk and suitable for multi-cell location. There is no available CSRA to indicate that the risk assessment was reviewed after one month in accordance with policy.

24 On 19 March, the man told staff that he had overdosed on diazepam. He said he had done so in order to get a "*buzz*" rather than because he was suicidal. He was re-located in healthcare and a Self-harm at Risk form (F2052SH) was opened by a discipline officer. The man was placed on an intermittent watch and observed for any side-effects of the overdose. The F2052SH clearly demonstrates that he was observed regularly and checks were made to ensure there were no adverse effects from the alleged ingestion of 28 diazepam tablets.

25 The man remained on the F2052SH until 30 March. The entries indicate that he had settled well, was interacting well with his peer group on the residential wings and required no further interventions from healthcare. Following a multi-disciplinary case review which included the man, it was decided to close the F2052SH on the morning of 30 March.

26 The man was transferred to HMP Leeds on the same day. The transfer was at his own request because of his mother's ill health, and it enabled him to be nearer his family. On his arrival at Leeds, a "health screen update" was undertaken. The mental health section of this document indicates that he had no history of deliberate self-harm and no concerns had been expressed. There does not appear to have been any consideration of the closure of the self-harm at risk form earlier that day.

27 A Cell Sharing Risk Assessment was completed on the man's arrival at Leeds, which again identified him to be a low risk and suitable for shared accommodation. This document was completed with little knowledge of the man and no documentation to support the decision making process. There are no entries in the man's history sheets from his time at Durham. Thus, when staff completed the CSRA at Leeds, they would not have had any knowledge about his previous behaviour, his compliance with regimes and his relationships with staff and other prisoners.

28 On arrival at Leeds, a history sheet was opened but it does not contain any entries that indicate how the man was coping with custody. The first entry is dated 2 July and it is a stamp noting information from the Prisoner Escort Form (PER) and that he was discharged to court.

29 An entry in the medical record shows that the man had pleaded guilty at court and returned to Leeds, on the Judge's Remand, to await sentencing. The entry also notes that he was not depressed or suicidal, and he declined to see the medical officer.

30 An entry in the medical record on 18 July, and a further entry on 25 July, indicates that the man may have been using illicit drugs as he was requesting detoxification. It was only after the second consultation that he began a subutex reducing programme. Towards the end of the 14 day programme, he again attended healthcare and requested a maintenance programme. He was advised by the medical officer that healthcare did not provide maintenance and so he was referred to the establishment's drugs services provider, RAPT. The man was seen by a drugs worker, but declined the help and support of the available services.

31 He had attended court on 22 December for sentencing and received an automatic life sentence. When he returned to the prison, he was seen by a healthcare worker and said that he had been *"expecting some big bird".* He said he was not depressed or suicidal.

32 Despite being sentenced to life imprisonment, he was not interviewed for the Post Conviction Immediate Needs Assessment (form LSPIA) until 13 January 2004. He told the interviewer that he had been in shock initially, but had settled

down and wanted to get on with his sentence, particularly because of the short tariff of two years and eight months. The man again said that he had no history of harming himself and that he was not suicidal. There is no reference to the F2052SH which was opened and closed after a period of approximately two weeks in March 2003. The initial allocation documentation was also completed that day. He said that HMP Gartree would be able to offer everything he needed to progress through his life sentence, but that he was prepared to change his allocation if it meant he would move to a first stage lifer unit at an earlier date.

33 Once again, there are no entries in the man's history sheet to indicate how he was coping with his sentence and custody in general. An entry in his medical record dated 29 February 2004 notes that he was admitted to healthcare with chest pains. By 2 March, this had settled down and he asked to return to the main prison. He was assessed as fit for return to ordinary location that day, and discharged from healthcare with a diagnosis of anxiety.

34 The man was seen on 23 March for his post-conviction induction interview, some three months after sentencing. The report indicates that he had earned enhanced status under the Incentives and Earned Privileges scheme. This is the first documented evidence of his behaviour whilst in custody. The report also notes that he had been employed as a cleaner whilst he was located on B wing.

35 The man's 'Lifer Profile' was completed on the same day. It stated that he was able to cope adequately in custody and was suitable for normal location. It also referred to adjudication for fighting which occurred at the end of February. This was his first adjudication during his sentence and he received seven days' loss of privileges following the finding of guilt.

36 The third report completed that day was the pre-first stage report. It noted that he had come to terms with his sentence and was willing to participate in whatever courses were necessary to affect an early release. Once again, his behaviour was said to be good and that he followed wing regimes well. He appeared to have a good rapport with staff and associated with a small group of other prisoners. He was keen to move to a lifer unit and get on with his sentence plan.

37 The next entries in both the medical record and history sheet refer to him being assessed as fit for transfer to HMP Dovegate. They are dated 1 April, and he transferred the following day when he was seen by healthcare staff who noted that he had no medical problems. Once again there are no entries in his records regarding the transfer.

38 An entry in the medical record refers to the man making lacerations to the inside of his left wrist on 19 May. Healthcare staff attended and he was admitted to healthcare for assessment. An entry in the medical record notes "*awaiting F2052SH*" but no F2052SH is available for the incident and no entry is recorded

in the available history sheets. A history sheet was opened which detailed his stay in healthcare. It is supported by a nursing care plan and a multi-disciplinary evaluation sheet. The entries suggest that the man settled in the healthcare regime and was polite and courteous to staff.

39 Shortly before he harmed himself, the man submitted an application to healthcare stating that he had been using heroin since arriving at Dovegate and had got into trouble. A pre-first stage lifer report indicates that he had been purchasing drugs for £50 for each purchase from other prisoners. He was unable to pay his debts and consequently had been subjected to bullying, intimidation and physical violence.

40 It was considered that due to the size of the drugs operation, "*there has been no wing safe enough to house him"* and so, for his own protection, he remained in healthcare whilst a transfer to another establishment was arranged and he could make a fresh start. Meanwhile, he agreed to engage with the local drug services and was assessed by the RAPT team who provide the Counselling, Assessment, Referral, Advice and Throughcare (CARAT) services.

41 The man was seen by the drugs worker on 27 May, and expressed a wish to address his substance misuse problem. He said that he wanted to get help and support, to avoid returning to drug use and ultimately to achieve complete abstinence. The drugs worker thought that he appeared motivated to address his drug problems and acknowledged the connection between his substance use and his offending behaviour. A care plan was formulated and agreed with him.

42 A transfer was arranged to Manchester in mid June. The RAPT team completed a form outlining the main issues the man had at the time and the outstanding goals that he still wanted to achieve.

43 The man transferred to Manchester on 16 June. The medical record notes that he was fit for transfer and had no outstanding medical appointments. There is no entry in his medical record to demonstrate that he was seen by healthcare staff on his arrival at Manchester. A Cell Sharing Risk Assessment was completed. He was initially allocated to G wing which is the induction wing, and remained there for a day before being transferred to C wing. He was given information about the prison during his first 24 hours.

44 Three days later on 19 June, the man was told that he would start work in Workshop 5 on 21 June. However, on 24 June he failed to attend work. The entry in the history sheet does not indicate the reason for his failure to attend or what, if any, action was taken. He again failed to go to work on 20 July and he was later given a warning, apparently for adverse comments. The same day he was moved from the 3's landing on C wing to the 4's.

45 The following day, the man was moved back to his old cell on the 3's landing after pleading guilty to a drug related charge at adjudication. He had tested positive for opiates during a mandatory drug test. The man lost 14 days' association, recreational PE, in-cell electricity and 50% of his earnings.

46 He appeared to settle down on the wing. On 15 August, the man's Personal Officer introduced himself and noted that the man said he was happy on the wing.

## EVENTS BETWEEN 24 AUGUST AND 4 SEPTEMBER

47 Just over a week later, the man applied for vulnerable prisoner status. He said that he made the application as he had, "Fears for his safety due to being in debt". He said he had got himself into debt through purchasing drugs. Initially, he had thought he could manage the situation himself but now realised that he could not do so. He was seen by a Governor, who approved his transfer to a wing. The man told the security department who was making the threats, and a Security Information Report was completed. The Security Manager's response to the information was to interview the man to ascertain the level of threat and also to implement the Anti-Bullying Strategy against the alleged bullies if there was substance in the perceived threat. The action plan was agreed by another Governor, but there is no evidence that it was carried out.

48 The man transferred to A wing during the afternoon of 24 August. Prior to being relocated, the CSRA was checked and he moved into cell A2- 105 with his cell-mate.

49 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.

50 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. On 30 August, The man's cell-mate passed a note under his cell door indicating that he and the man believed that their lives were in danger from another prisoner. They were interviewed the next day about their concerns. His cell-mate said that he believed there was a "large price on his head". They were anxious about what he might do and expressed concerns about their personal safety.

51 A further entry in the wing observation book notes that the man and his cell-mate refused to go back to their cell on 1 September. There are no entries in the man's history sheet to indicate the reasons for refusing to relocate, or of any subsequent support or advice to the man and his cell-mate. However, they did return to the cell peacefully after discussions with staff.

## DISCOVERY OF THE DEATHS

52 On 4 September, the Officer in charge carried out the morning 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 4's landing, working down. He got to cell A2-105 at 6:48am and looked through the observation hatch. He noticed two prisoners apparently 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. He immediately put out a radio call for urgent assistance and ran to pick up the suicide box.

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

54 The four staff began to take the man and his cell-mate's weight and remove the ligatures, which was made more difficult because the space was limited and because both men had oil on their feet which made them slippery. By the time they had removed the ligatures, healthcare staff had arrived. The staff withdrew from the cell to make space for healthcare staff to work. Two Nurses immediately assessed the situation. It was evident to them that both men had been dead for some time. The nurses made the appropriate clinical decision that they would not attempt to resuscitate the men.

55 The ambulance, with paramedics, arrived at the prison at 7:01am. They were quickly escorted through the prison and entered the cell. The paramedics noted that both bodies were cold to the touch and the pupils were fixed and dilated. The Paramedic attached a defibrillator, first to the man's cell-mate, and then to the man, but there was no cardiac output from either. There was nothing more that they could do to assist and so they departed.

56 The Doctor attended at 10:35am and certified the deaths of both the man and his cell-mate.

## ACTIONS AFTER THE DISCOVERY OF THE TWO MEN

57 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 another arrived two minutes later. By 7:08am, it was evident that two ambulances were unnecessary and so the second left the prison.

58 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, which they noted was locked and secure. A prison officer was located outside the cell to act as a log keeper.

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

60 The Governor, the Duty Governor, the Care Team, Independent Monitoring Board and Chaplaincy were all notified of the events. When the Governor and Deputy Governor, arrived at the prison, they were briefed by the first Governor that arrived.

61 The Duty Governor and chaplain were asked to visit the families of both men, after the chaplain 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 cell-mate's home. On arriving in his area, the Duty Governor, the chaplain and the two Family Liaison Officers (FLO) went with local police to visit the man's cell-mate's family. The man's family had apparently declined a visit from the prison staff, and so the Greater Manchester Police FLOs went alone to visit them.

62 Significant numbers of police were in attendance at the prison 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.

63 The Operation Support Grade (OSG) had been the night patrol on duty during the night of 3/4 September and carried out a roll check in the morning that the men were discovered. He had gone off duty by the time that they were discovered, and at 7:40am a message was left on his mobile phone at the Governor's request. At 7:57am, The Night patrol Officer 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.

64 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 Night Patrol Officer 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

65 The man did not cope with prison custody. He moved from Dovegate to Manchester after being bullied and getting into debt for continued substance misuse. He had previously harmed himself by taking an overdose of prescribed medication on one occasion, and cutting his left wrist in a separate incident.

66 Following sentence, the man was required to have an immediate assessment to enable the completion of the Post Conviction Immediate Needs Assessment (LSPIA). This did not occur for over three weeks after sentencing. Whilst the delay in the man's case would not have had any bearing on his tragic death, it could be of significance in other cases.

**The Governor of Leeds should remind staff of the importance of completing such documents in a timely manner to ensure their immediate post-conviction needs are met promptly.**

68 The man transferred to Manchester on 16 June, but the very limited entries in his history sheets do not provide a satisfactory picture of his time there. He asked for vulnerable prisoner status in August, and requested a move from C wing for his own protection. He said that he feared for his own safety, stating that threats were coming from one prisoner and others acting on his behalf. The man also gave information to staff about a weapon hidden on C wing.

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

69 The Wing Manager did not follow up the action points identified by the Security Manager following the Security Information Report (SIR) submitted on 24 August 2004. He was required to speak to the man and establish the level of threat, but this did not happen.

**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.**

70 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.**

71 There is clear evidence of appropriate levels of support for staff directly involved in the tragic deaths of the man and his cell-mate. 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 two 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.**

72 Nothing I have seen has suggested that the actions of the man and his cell mate could have been predicted, or directly prevented by prison staff.

## 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. The Governor of Leeds should remind staff of the importance of completing such documents in a timely manner to ensure their immediate post-conviction needs are met promptly.