INVESTIGATION INTO THE CIRCUMSTANCES

SURROUNDING THE DEATH OF MAN AT HMP WHITEMOOR

IN NOVEMBER 2006

Report by the Prisons and Probation Ombudsman for England and Wales

September 2007

This is the report of an investigation into the circumstances of the death of a man on 19 November 2006 at HMP Whitemoor. He had been found in his cell, hanging from his upturned bed. .

I would like to offer my sincere condolences to his family and those touched by his death.

The investigation was undertaken by four of my investigators. Both they and I would like to thank the Governor of Whitemoor, the prison's appointed liaison officer for their cooperation during the course of our inquiries.

The man was a resident in the Dangerous and Severe Personality Disorder (DSPD) unit at Whitemoor. The unit is one of only two DSPDs within the Prison Service. It has specialised staff who run a unique regime of group and individual support, as well as courses to help improve prisoners' medical conditions and challenge their offending behaviour.

The man had been in the DSPD unit for approximately 18 months. In this time he had been continuously assessed by a multi-disciplinary team of psychiatrists, psychologists, nurses and discipline staff. He had been a prolific self-harmer, often presenting with very challenging behaviour.

After several drug treatment regimes to help with his condition, he was given depixol. He had an extreme reaction to this medication, and developed a growing fixation with his medical problems. During the night of 18 to 19 November, he blocked the observation hatch in his cell door, barricaded the door with his bed, and used a ligature to hang himself. It appears that he had planned his death.

The treatment that the man received in Whitemoor was of a high standard. But I am not certain that every member of staff performed all the checks that were required of them on the night of his death. I make a total of four recommendations. Two of these relate to improving procedures for responding to emergencies. However, I should also say that I have been impressed by the speed with which the governor addressed other matters brought to his attention during the course of the investigation.

Following the inquest regarding this death, I have redacted the report to protect the anonymity of the man and his family.

Stephen Shaw CBE
Prisons and Probation Ombudsman **September 2007**

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SUMMARY

The man who died began a ten year sentence for serious offences against his partner in April 2003. After spending time in both Exeter and Albany prisons, he was transferred for assessment to the Dangerous and Severe Personality Disorder (DSPD) unit at HMP Whitemoor in May 2005.

He found it difficult to cope in prison. He was a prolific self-harmer, but there is no indication that he had made any serious attempt on his life whilst in prison, prior to his death on 19 November 2006. He was supported and managed through the Assessment, Care in Custody and Teamwork (ACCT) processes for virtually all his time in custody. Together with self-harming, he would frequently cause damage to property and make threats to others (although he did not hurt anyone else in prison).

The assessment period concluded on 29 October 2005. The psychiatrists and psychologists concluded that he met the criteria to be accepted for treatment in the DSPD. He was given a definite diagnosis of borderline personality disorder and obsessive-compulsive personality disorder.

His pattern of behaviour continued for some time. At times he appeared to be improving and then he would regress. The level of attention and commitment from staff was high. He was regularly reviewed by a multi-disciplinary team. Along with a range of therapeutic interventions, he was treated with different medications. After several months of trying different drug treatments, the lead psychiatrist decided, with his agreement, to try some depot medication, depixol. (This medication acts by blocking a variety of receptors in the brain, particularly dopamine receptors.) He was given the first dose on 15 May 2006, and a second dose five days later. After this injection, he rarely self-harmed or spoke of his offence and victim which had previously been a preoccupation. However, his attention turned to the side effects of the medication.

At first, he was restless and felt the need to move, but this eased over time. However, he began to find daily tasks difficult. He spoke of “time lasting longer than time”. He found movement difficult and complained of pains in various parts of his body. He had to be encouraged to eat and wash. He remained under close supervision and various medications were used in an attempt to allieviate these problems. The lead psychiatrist also sought advice from a pharmacist as to possible side effects. She also referred him to a neurologist who concluded that there was nothing neurologically wrong.

In August and September 2006, the man self-harmed on three occasions and was again subject to ACCT procedures. In October, he moved from red to green spur. He was uncomfortable with the move as he had built up trusting relationships with a number of staff on red spur. Other prisoners from red spur moved at the same time, including one of his friends.

On 16 October, staff decided to close the ACCT. They continued to provide a high level of support and a care plan was in place. The man had said that he wanted to die. A number of prisoners and staff heard him say this on many occasions.

Many clinical staff said they had never seen a presentation of illness like his. They had tried a number of therapies. The lead psychiatrist decided to refer him to a psychiatric secure hospital to ask if they would admit him for a period of assessment. She was hoping they would be able to provide views or further suggestions on how to best care for him. The letter had not been sent by the time of his death.

The day before his death was his birthday. He had received a card from his brother, and had a birthday lunch with his friend. Significantly, he gave a number of CDs to his friend. He also telephoned his brother. During the conversation, he complained of feeling physically and mentally unwell which he attributed to the depot medication.

That evening, he pressed his cell bell on three occasions. He asked for some spellings from a staff member. It later became evident that he had used them in a note found in his cell explaining his actions. He also asked for some toilet paper with which he blocked the observation panel in his cell door. Finally, he asked the female officer not to check on him again as he was about to strip wash.

When an officer conducted the early morning roll count, his observation panel was blocked. The officer could not make visual contact with him and did not attempt verbal contact. The officer said in interview that he thought he heard him moving. My investigator informed the governor of this matter and he subsequently launched an enquiry into the conduct of the officer. It is recommended that all staff are reminded of their responsibilities in checking prisoners.

It seems that the man had planned his actions. He warned staff not to come to his cell. He blocked the observation panel. He turned his bed upright, and moved it to act as a barricade to the door as well as a ligature point. He also appears to have taken several steps to ensure it would be difficult for him to breathe, or for staff to resuscitate him.

On the morning of 19 November, after day staff had received no response during their roll count, they found him hanging in his cell. There were clear signs of rigor mortis. Whilst staff acted with the best of intentions, a number of issues became evident during this investigation regarding the management of the emergency situation. Staff were not equipped with ligature knives and had to run to the wing office to get ligature scissors. They were unclear as to whose responsibility it was to call an ambulance. The nurse commenced cardio pulmonary resuscitation despite the presence of rigor mortis. Some of the contingency plans conflicted with others. However, a family liaison officer was quickly appointed and, along with a governor, visited the family to break the news.

My report concludes that, during his time at Whitemoor, the man received a high level of care and support from experienced and skilled staff. However,the investigation raised concerns about safer custody issues such as the checks on the night of the man's death, the lack of ligature knives and movable beds. The governor has acted quickly to rectify the problems identified. The main finding of this report is the need to review emergency procedures, including raising staff awareness of their responsibilities in emergency situations.

THE INVESTIGATION PROCESS

1. I appointed one of my investigators to lead the investigation on my behalf. She visited HMP Whitemoor where she met the governor. On her initial visit, she was given a tour of the prison, including the cell where the man had died. She met with members of the local committee of the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB).

2. Notices were issued to both prisoners and staff, inviting anyone who might have relevant information relating to the man to make themselves known. One prisoner came forward and was interviewed.

3. One of my family liaison officers contacted the man's family. His family had been concerned by the injections that he had received, and had raised concerns with his probation officer. They also wondered whether hospital might have been an appropriate place, given the side effects that he suffered. The family also questioned why his bed was so easily moved. These issues are considered later in this report.

4. The lead investigator returned to Whitemoor with fellow investigators and the Secretary to the Forum for Preventing Deaths in Custody. The investigation team interviewed prison staff and prisoners, both formally and informally. The team examined the man's prison record, medical records and a series of prison documents. They also assessed the care that he received against Prison Service standards, orders and policies. A clinical review of his healthcare in custody was carried out by Cambridgeshire and Peterborough Mental Health Partnership NHS Trust.

HMP WHITEMOOR

5. Whitemoor is a maximum security prison for category A and B male prisoners. It is one of eight high security prisons. Whitemoor's Dangerous and Severe Personality Disorder (DSPD) unit opened in 1999. It is part of the Government's pilot DSPD programme, a joint initiative between the Department of Health, Home Office and Prison Service. This initiative aims to develop new mental health services for a small number of people who may be dangerous as result of a severe personality disorder.

6. Whitemoor also has a Close Supervision Centre (CSC) which opened in October 2004. The unit is a small therapeutic centre aiming to provide a supportive, safe, structured and consistent environment.

Background to Dangerous and Severe Personality Disorder (DSPD) and the DSPD units

7. There are currently four DSPD units: two in high security prisons (Whitemoor and Frankland) and two in special hospitals (Broadmoor and Rampton). Together, these units provide over 300 places. Over 200 of them are currently occupied. The places are in high demand with over 600 referrals in an 18-month period. This is not surprising given that current estimates indicate that some 2000-2500 people in custody meet the DSPD criteria.[1] By the end of November 2006, a total of 123 prisoners had been assessed at Whitemoor's DSPD unit and 75 were undergoing treatment.[2]

The role of psychiatry

8. Within the DSPD unit, the role of psychiatry fits within an overarching psychological model of treatment (in contrast to the predominately medical model of most mental health service provision). The main focus of the treatment model is facilitating change in the personality disorder (and the associated risk), but the management of mental and physical health problems is also important. One of the psychiatrists' specific contributions to treatment is in the form of prescribing and managing psychotropic medication. Compliance with medication is monitored as far as possible (recognising that disposal, hoarding or trading medication may be a manifestation of personality disorder). Medication is not administered without the consent of the prisoner.

Nursing interventions

9. Many prisoners will experience episodes of crisis throughout the phases of their treatment. The nursing team plays an important role in attending to

[1] Data provided by the DSPD Programme Unit.
[2] Home Office website.

prisoners in distress. The nurse's role is interwoven into the model of treatment. Through interpersonal, psychological and behavioural nursing techniques, they try to reduce prisoners' physical and psychological distress. Nurses play a key role in supporting prisoners through periods of crisis, and the manner in which this is done is intended to enable prisoners to see themselves in a more positive light.

The role of discipline staff

10. The model of treatment on the DSPD unit is at odds with the traditional role of prison officers. It has been recognised that discipline staff working on the unit have had to adapt to a style of working that focuses on the treatment of individuals rather than on the management of them. A senior officer (SO) told the investigation team that discipline staff on the unit tend to fall into two distinct groups: those who consider themselves in the more traditional landing officer role and those who identify more with their role as group workers. All officers receive some mandatory training (such as a three day course on personality disorder awareness), but the officers who work with the groups also receive training in skills to equip them to lead cognitive interpersonal groups. This training is delivered on an ongoing weekly basis. Discipline staff tend to work exclusively on one unit within the DSPD unit.

Occupational therapy

11. Aside from individual therapy and group work, prisoners in the DSPD unit have access to education, gym, employment opportunities and training workshops. Some prisoners have work outside the unit as there are few employment opportunities within it. One of the unit's senior officers told the investigation team that there are plans for occupational therapy to be available to prisoners in the evening.

KEY EVENTS

12. From the beginning of his sentence in 2002, the man found it difficult to cope with prison life. He felt great remorse for his crime and was filled with self-loathing. This led to habitual and serious self-harm which took a number of forms including food refusal, cutting, swallowing and inserting objects. At times, staff also found him quite difficult to deal with as he would often make threats towards them and other prisoners.

13. The man moved to Albany in June 2003. He still found it difficult to cope and was seen by mental health services. He was making attempts to contact his victim and her family. He was also continuing to act aggressively towards others and himself. His self-harm was alarmingly regular.

14. In 2004, his mother died. He took this badly, and his pattern of behaviour continued. Staff at Albany consulted the DSPD unit at Whitemoor as to whether he would be an appropriate candidate for their programme. For the majority of this time, he was subject to the F2052SH procedures (since replaced by Assessment, Care in Custody and Teamwork – ACCT). These are processes to support and supervise those judged at risk of self-harm and/or suicide.

15. The man moved to the DSPD unit at Whitemoor in May 2005. He was housed on red spur, the assessment unit. On arrival, he said he did not want to take the medication for his heart condition. He said that he knew the consequences of not taking medication, and he wanted to die although he was not planning to take his own life. He was still subject to F2052SH procedures. Within days of his arrival, the assessment of suitability for treatment began.

16. On 5 June 2005, staff decided to close the F2052SH as he appeared to have settled in and was much calmer. That afternoon, he self-harmed by cutting his wrist. He was paranoid that staff had been laughing at him and was aggressive. He also experienced chest pains and was given GTN spray to alleviate them. The cut to his wrist was particularly deep and clinical staff noted that, “The man seemed determined to kill himself.” The F2052SH was re-opened and he was moved to the ’gated cell’. (This is a cell with a gate door rather than a solid door, and allows staff to see clearly in the cell at any time.) From then until the end of October 2005, he self-harmed on at least 13 occasions. For the most part, he refused medical help when he did so.

17. The man made threats to others on at least eleven occasions. He had also smashed his cell, and started a dirty protest which had led to a closure of the showers on red spur. Some prisoners felt that he was developing an unhealthy interest in the female staff. His behaviour made him unpopular with some prisoners, and he received threats from others. Staff felt that he was trying to make himself disliked so another prisoner would harm him. During this time, he had written and handed to staff

confessions to other crimes which later proved to be false. He also tried to contact his victim's family on several occasions. He was constantly subject to the F2052SH procedures and intermittently spent time in the gated cell.

18. A similar pattern of behaviour continued for some time. However, staff felt that he was generally slowly improving and he self-harmed less often. In a care plan drawn up on 1 May 2006, the general feeling was that there had been a slow, sustained improvement in his behaviour. However, this was interspersed with several regressive episodes. Staff considered the possibility of introducing time-limited attention as he would talk at length to them if allowed to do so.

May to October 2006

19. In the first two weeks of May, the man flooded his cell and made threats to other prisoners and himself on four occasions. After discussion with him, the lead psychiatrist decided to try depot medication of depixol. This acts by blocking a variety of receptors in the brain, particularly dopamine receptors. (Dopamine is involved in transmitting signals between brain cells. When there is an excess of dopamine in the brain, it causes over-stimulation of dopamine receptors.) The medication blocks these receptors and stops them becoming over-stimulated, thereby helping to control psychotic illness. Giving the depixol by injection releases the medicine slowly over a period of two to four weeks. This is known as a 'depot' injection.

20. The lead psychiatrist described the depot injection given on 15 May as a "test dose". At this time it was felt that the man had a good response without evident side effects. He was given a further 40mg dose five days later. After this second dose, he only self-harmed once until August. Similarly, with the exception of one incident where he smashed two cells on 30 June, he did not behave aggressively again. However, a few days after the second dose, he developed a marked feeling of inner restlessness and urge to move. Staff and prisoners told my investigators that he would just keep walking and moving constantly. This continued for about four weeks before gradually subsiding.

21. Due to his response to the drug, he had no further injections but was started on amisulpiride (100mg) a day – an antipsychotic drug. Within four to five days, he had developed what the lead psychiatrist described as "marked akathisia [a slowness in movement, small muscle movement] with Parkinson facies [immobile, expressionless, mask-like], and very little movement."

22. The man remained under close supervision by both clinical and discipline staff. The doctor gave him carbamazepine. This is a drug used to treat disorders such as manic depression. The man was distressed at the change in himself, and spoke a great deal about how he was feeling. He

did not feel the carbamazepine was helping. On 21 July, the lead psychiatrist doubled his dose of carbamzepine and noted that he was also on sleeping tablets. The nursing handover sheet notes that he seemed "lost and distressed".

23. On 26 July, the man attended a one to one session with his therapist who noted that the depot medication had brought his behaviour under control, but had resulted in severe side effects that had since gradually diminished. Nevertheless, he remained convinced that they had not entirely gone. He complained of continuing discomfort in his legs and worried about permanent damage. The therapist felt that his response to the side effects was typical of how he responded to most problems in his life, in that he became obsessional, constantly ruminating and seeking reassurance. The therapist further noted that the man had little concept of time and had disruptive sleep, unable to think about anything other than his mental state. Wing and clinical staff recorded that he had not been eating all his meals and was having to be encouraged to care for himself.

24. On 28 July, the man approached the lead psychiatrist on the landing. The doctor wrote in the clinical record that the man repeatedly expressed distress about "time lasting longer than time", his legs and a feeling of restlessness. Following their conversation, the doctor contacted the pharmacist at Helsdon Hospital, Norwich, to follow up a telephone request made earlier in the week. The doctor gave an account of the man's medication, side effects and current symptoms. The pharmacist thought the side effects to be a result of the depot injections which could take two months to fully leave his system. The pharmacist felt the akathisia was unlikely to be due to the amisulpiride, but agreed it was appropriate to report the issue. He wondered whether the symptoms might be due to depression. After this conversation, the doctor spoke to the man and told him of the pharmacist's views about the side effects and how long they might last.

25. On 2 August, the lead psychiatrist wrote to a consultant neurologist at Edith Cavell Hospital, Peterborough, to request a neurological assessment. The letter says that, after a period of increasing instability on the man's part, the lead psychiatrist had prescribed a test dose of depixol depot medication (20 mg IM on 15 May). It reports that he made a good response without evident side effects, and was given a further 40mg some five days later. A few days after the second dose he developed marked akathisia. This continued for about four weeks before gradually subsiding.

26. The akathisia was the main reason for the lead psychiatrist's letter. Apparently, this is an unusual side effect for a low dose of an anti-psychotic medicine, but is frequently a presenting symptom of idiopathic Parkinson's disease. The lead psychiatrist wondered if the reaction to the medication was an indication of the development of the disease.

27. The lead psychiatrist wrote that as well as the continuing shuffling, the man looked almost catatonic, needing active support and prompting to

care for himself (eating, drinking, washing etc). The amisulpiride was stopped as soon as these symptoms became apparent. They gradually disappeared over the next few days.

28. The second part of the letter explains that the man had also developed a new set of symptoms, largely psychological – poor concentration, unable to occupy himself and some heaviness/restlessness of his legs. He was also repeatedly reflecting upon whatever was preoccupying him at the time, e.g. his offence, guilt, and the side effects of his medication. The lead psychiatrist explained that these symptoms had already been discussed with an experienced psychiatric pharmacist who believed the majority of the symptoms to be related to the depot medication.

29. The following day, he was prescribed quetiapine (25mg) for seven days. This medication is an anti-psychotic drug.

30. On 4 August, the man harmed himself by cutting his neck. A nurse visited him on the wing to clean and dress the wound. He told the nurse he was unable to cope, and that he could not even concentrate to watch the television or listen to music. An ACCT form was opened.

31. The man self-harmed again several days later using razor blades. He was having a great deal of interaction with clinical and discipline staff. Clinical staff spoke to him every day, as evidenced by daily notes in the nursing handover sheet. At this time, they were noting when he ate, drank, and managed to clean his cell.

32. The man's personal officer told my investigators that he felt that the man's behaviour had been largely about self-punishment. He had built a trusting relationship with him. He felt that the man was ashamed of his offences and would sometimes take his anger out on property and the cell. Although he sometimes threatened to, he never hurt anyone else in prison.

33. However, his personal officer said there was quite a change from August:

> "The last six months prior to his death, he was a slightly changed character, he was always saying it was his change in medication that he went on to. He became very morose he was stating 'I don't have any family, I don't have any friends', he had lost his outside contacts and we had to strive very hard to actually encourage him to write whereas before he was always prepared to write to people ... The letters were coming in but he was writing nothing out. I said ' You've got to keep your contacts', and then he was stating 'well I haven't got anything' … it was a difficult period for him I would say from about the August through to his death."

34. On 1 September, the team of psychiatrists reviewed his care. He again complained that his body was not functioning as it should be, although his memory was clear. The clinical record notes "repeated requests for help". The psychiatrists reassured him that they were awaiting an appointment

with a neurologist. They decided not to change the dosage of his medication and to review it again in two weeks.

35. Early in the morning of 4 September, the man cut the right side of his neck with a razor. He pressed his cell bell and told staff. Another ACCT was opened. Later in the day, he underwent an ACCT assessment with the assessment officer. The man told the officer that he believed his problems were related to a reaction to the depot medication he had taken four months previously. The man said the self-harm was not a suicide attempt but a cry for help. He cut his neck and scratched his victim's name into his left forearm. The officer noted that the man had been unable to concentrate and was constantly picking his ear, fingers and lips during the assessment. He felt the man was incapable of engaging in rational conversation. The man said that, although he did not want to harm himself any more, he did feel like dying. The officer noted that the man had previously said that he had no reason to live. The man said that he had been seen by the neurologist and he was anxious about the result of the consultation.

36. Following the ACCT assessment, a multi-disciplinary team (together with the man) held a review of his ACCT document. During the review, the man spoke in riddles, and said he felt hopeless. He kept speaking over others and repeating himself. It is recorded that he wanted help from others, but seemed to struggle to help himself. Many staff noted that he could not seem to move on and was repetitive in his complaints.

37. On 7 September, the lead psychiatrist received a letter from the consultant neurologist at Edith Cavell Hospital, regarding his consultation with the man several days earlier. The neurologist found the man to be extremely depressed and introspective. The assessment concluded that, although he was demonstrating some slowness in movement and response, he was not genuinely akathenetic in a Parkinsonian sense and there was no rigidity. His reflexes were normal. The doctor attributed his neurological state to his underlying psychological condition and the side effects of the anti-psychotic medication. He did not feel that there was any real evidence of alternative neurological pathology and, apart from avoiding anti-psychotics as far as possible, he could not suggest anything else. The consultant neurologist stressed that if the lead psychiatrist remained concerned about the man, he would be happy to review him, but no arrangements were made to do so at the time.

38. Staff held an ACCT review on 11 September. The man presented as highly anxious and very low in mood. He said he could not perform daily tasks such as washing. The review concluded that he was not suicidal but was very low and needed ongoing support.

39. The next ACCT review was held a week later. The man was feeling the same, adding that doctors did not know what was wrong with him. Officers spent time with him, even sitting and listening to a CD with him. Some staff reported that he was able to complete some tasks. The review had a

sense of exasperation about it. It was clear a range of support had been offered to him, and it was felt he really needed to engage and show a level of commitment. In the care map, they agreed that he was to see the nurses and his therapist every day to discuss his emotional issues. The man agreed to try to shower daily and keep himself and his cell clean. It was also suggested that he should speak with a member of staff for five minutes every day about a subject other than his health.

October to 17 November 2006

40. Over the next week, there seemed to be a slight improvement in the man's demeanour. He did manage to speak to staff about things other than his health, and was spending time with his friend and fellow prisoner. However, he seemed to think he had not made progress. At his next ACCT case review on 2 October, he said he still felt hopeless. Staff noted that he smiled and laughed twice during the review. This was a real contrast to his normal demeanour and the session ended in good spirits.

41. The man failed to attend the group therapy sessions. Staff set him the challenge of completing a daily tasks sheet. This consisted of things such as washing himself, having a shave, cleaning his cell etc. The aim was to attempt to help him get into some sort of daily routine. Staff commented that he seemed more positive, although he maintained he was insane.

42. On 3 October, a probation officer visited him to check his welfare. This was in response to concerns raised by his family after the man had told them of problems he was experiencing following his injection. The man began to deteriorate again. He complained that he was losing his hearing and kept getting upset and crying. He was due to move to green spur. (Ordinarily, prisoners only stay on red spur during their assessment). The man had stayed on red spur longer, as staff wanted the group with whom he had been assessed to move together and had to wait until there was room on another spur.) The man was anxious about the move. He had formed a trusting relationship with a number of staff primarily based on red spur. They had spent a great deal of time with him and were used to dealing with him.

43. The man continued to report a loss of hearing, together with bad eyesight, and described himself as "a dead man walking". He moved to green spur around 12 October, as did his friend His friend told my investigators:

> "He [the man] was always depressed but I think he became a bit more depressed, you know and his appearance was at times you'd have to tell him to go and get a shower and that and clean his cell and things like that, you know, yes. But apart from that he was, generally he was the same you know apart from complaining about how his legs and arms were and he was always on about that."

44. The man's personal officer had daily contact with him on red spur. On green spur, contact was very limited, although his personal officer did

make an effort to go to see him on several occasions. It is not clear whether he was allocated another personal officer after his move.

45. Over the next few days, he complained that he could not move his arms or legs properly, sometimes not attending to get food or medication. On 16 October, he attended another ACCT review. He talked at length about his problems with the depot injection and his struggle to get up. He said that he did not want to self-harm. He said he wanted to die, but he was not physically able to kill himself. He maintained that no one understood him or could help him. He admitted that the self-harm had been in part an attempt to get more one to one attention. A decision was made to close the ACCT.

46. The following day, the man was on the landing of green spur. He saw a gate open that would enable him to get onto red spur and he ran towards it. The man was restrained by staff and taken back.

47. On 8 November, the man started to write a letter to his victim's mother. He finished the letter the night before his death. Staff noticed that he was not venturing out of his cell much despite encouragement, and was only eating intermittently. On 10 November, an officer made a note in his wing file that he would not come out of his cell and "appears to have given up".

48. On 16 November, the lead psychiatrist wrote to the referrals manager at the Butler Clinic, Langdon Hospital. He asked for the man to be assessed with a view to transferring to the hospital for further treatment under section 47/49 of the Mental Health Act. In the event that he could not be admitted to the clinic, the lead psychiatrist requested an opinion on treating his condition and the possibility of involvement in his resettlement plans. However, this letter would not have reached the clinic before the man's death.

18 and 19 November 2006

49. Saturday 18 November was his 31st birthday. He telephoned two of his brothers and had received a card from one of them. He did not talk to his first brother for long. In the second call, he spoke for several minutes but his phone credit then ran out. During this conversation, he said that he had lost the hearing in his left ear as well as his sense of smell. He said:

> "I can't stop picking, I'm in agonies of pain, I can't function, I can't make a bed - I can't watch TV ... I'm dead you see, I died at 30 … You see my mind's gone … and there ain't no way out. I'm never escaping me own self."

50. He went on to complain that he felt like his body was moving forward and back, although he knew it was not:

> "I wake up every morning at half past three … and I can't function and I want to function, and I genuinely can't function. I'm in that bed in

agonies of pain, arms under the pillow, all from half past three in the morning 'til about 10 – 11 o'clock at night when I fall back to sleep again when the brain shuts down. That's my life … and then I've got to function to clean the cell and I can't."

51. The man's brother sympathised. He checked that he was able to wash, offered encouragement and urged him to talk to staff. He asked what he was going to do that day. The man replied:

> "I'm only out now to play some CDs because I've got to escape my own self … It tortures me, everything mentally tortures me. Everything and everyone … Anyway I've only got 3p left, I've got to go. But thanks for the card … Remember what I tell you I never went insane, I never done this to myself. It's total cruelty and inhumane what they've done to me. And to leave me like this and to know there's no cure and there's no way out."

52. The man's friend said he made him a special dinner and gave him some chocolate for his birthday. The man showed him the birthday card he had received from his brother. The friend recalled that several days before his birthday the man had repeatedly said, "Can I trust you friend?" he thought that by saying this the man was trying to tell him something, but knew that he would tell staff if he thought the man was going to harm himself. The man also gave several CDs to his friend and said "remember me". The friend said that he did not think this was unusual as he was often saying odd things such as asking him to say a prayer for him. He had known him for about 18 months, and he had often made comments that he was a dead man walking. He had no suspicions that anything was different on this occasion.

53. Another prisoner said that the man had been upset that afternoon and had approached an officer. The prisoner alleged that the officer had said he was too busy to talk. The prisoner said that later that afternoon he had raised his concern about the man to the same officer. My investigator interviewed the officer concerned. She also made enquiries of other staff and prisoners as to staff attitude and response to him. The investigator was satisfied that the man received a good level of care.

54. All prisoners on the DSPD were locked in their cells at approximately 4.30pm. The man's cell was located in between two others. The prisoners in both the adjacent cells were category A and therefore subject to regular checks throughout the evening and night.

> "… he was in darkness, we turn all the lights off so it's complete darkness and he said "hello, can you give me some spellings please?" so I said yes. And there's a little, what we call a night light outside, so I put that on. He passed me the piece of paper out that he wanted me to write spellings on. I took that and I still couldn't see, the light wasn't that good, so I asked him to put the main light on in his cell … he was

> fully dressed, his cell was in the same order as what it usually was, bed was in the right place and everything because I did have a look. He asked for three spellings … [they were] anxious, distressed and slip. At that time I didn't think that they were strange spellings but something must have told my conscience because I asked him who he was writing to and he actually said to his therapist. I asked him if he was okay, he said yes fine, so I said okay, if you need anything put your cell bell on."

55. A prisoner occupied the cell directly below the man's cell. He remembered hearing an officer talking to him about some spellings, and recalled the officer telling him that if he needed anything he should use the cell bell to contact her.

56. The final time he used his cell bell was at 10.43pm. When the prison officer attended, he said he wanted to warn her that he was about to have a strip wash so she should not come to check on him. The officer asked again if he was okay, and he replied that he was fine.

57. The prisoner said that he heard banging noises coming from the cell directly above him. He considered this to be unusual from him. He believed he heard the man moving his bed. He could not be sure of the time but believed it may have been around 11.00pm.

58. My investigators also asked to speak to the prisoners located in the cells either side of him. One prisoner declined to be interviewed, but a second prisoner told my investigators that he remembered the evening well. He had been unwell on that particular evening and the pain had kept him awake for most of the night. He recalled hearing the man moving his furniture. He said he could not be sure of the exact time as he was dozing, but he thought it was around 11.00pm or midnight.

59. Throughout the night, staff are required to perform 'pegging checks'. These are patrols in which the officers use an electronic wand to "peg" at specific points. The pegging points are in different positions over the landing. At the beginning of a night shift, an officer is given a list of the points s/he must cover at certain times. This ensures that the officer is patrolling the wing, at random intervals. It does not require staff to check individual cells. Staff also have to check on those subject to ACCT documentation, as well as make regular observations of category A prisoners. On the night of 18 to 19 November, the patrols were shared between the first and the second prison officers. A third prison officer, was also on duty, assigned to the gated cell which was holding a prisoner considered to be at a high risk of self-harm. Unless a prisoner is classed as category A, or is subject to ACCT procedures, they would not be checked between the evening roll count and the roll count the following morning. In this man's case, he was seen after the evening roll count when staff responded to his cell bell.

60. In the morning, staff are required to perform a roll check. This involves every officer checking every cell. They also have to make a visual or

verbal contact with every prisoner. The second prison officer signed to say this check was performed at 5.25am.

61. The second prison officer told my investigators that he conducted the roll check at the same time as 'pegging' over the course of an hour. He said that he remembered checking the man's cell sometime between 4.10 and 5.15am. He recalled that a prisoner was in the cell next door to the man's and he was awake at that time. He had checked that prisoner as both he and the prisoner in the cell the other side of the man were category A. He checked the man at the same time. My investigator asked if he saw him or if something was obscuring the observation panel. He replied, "at that time there was, but I was happy, I could hear him in his cell". He said that he did not try to get a verbal response as he could hear movement. The prisoner next door also thought he heard movement from the man's cell in the early hours of the morning. The checks of category A prisoners are recorded and those records show that the prisoner next door was checked at 0.01am, 1.48am, 3.31am, 5.20am and 7.05am.

62. When the morning staff arrived, they began the morning roll count. A fourth prison officer started to check green spur at approximately 7.20am. He could not get a response from the man's cell, and asked the second prison officer to try and get the man to talk to him while he continued the checks. The second officer went to the cell. The observation panel was blocked by toilet paper. A fifth and sixth prison officers and then tried to get a response from him.

63. Each cell has an inundation point. This is a small access point through which a hose can be inserted in the event of a cell fire. The sixth officer collected the key and looked through the inundation point, but the view was obscured by the man's mattress. He thought that the man might have barricaded his cell. The prison was in patrol state. (This means that all prisoners have to be in their cells, with the doors closed, unless there is an emergency. Patrol state is due to either staff movement or reduced staffing levels.) Staff asked permission to unlock his cell. There were plenty of staff around, as night staff were still on duty. The orderly officer therefore authorised the opening of the cell.

64. The sixth officer told my investigators that, through the crack at the edge of the door, he could see that the bed had been moved. It took all his strength to open the door. The fifth and sixth officer found the man hanging from his upturned bed. The man had put toilet paper up his nostrils, a plastic bag over his head and then hanged himself with a shoe lace. The officers supported the man's bodyweight and another officer went to get the "suicide box" and ligature scissors. The third officer entered the cell and helped take the man's bodyweight. The sixth officer removed the bag from the man's face. One of the officers cut the ligature. They placed him on the floor and tried to find a pulse. The officers told my investigators they saw very clear signs of rigor mortis and were unable to find any life signs. Nursing staff then arrived and attempted resuscitation.

65. The first nurse received a telephone call in the healthcare centre. She was informed that there was somebody hanging on D wing. She, accompanied by another nurse, collected the emergency bag and oxygen and ran to D wing. In spite of the distance and heavy equipment, the first nurse thought it only took them a few minutes. She told my investigators that, as she was approaching the cell, she asked staff if the paramedics had been called and was told that it would be done straight away. It is unclear whether paramedics had been called prior to this. In any event, there was no significant delay in their arrival.

66. The first nurse said that on arrival at the man's cell, there were no signs of life. He was cyanosed (a blue colouring of the skin), there was clear evidence of rigor mortis and his pupils were fixed and dilated. The first nurse's understanding was that she should continue cardio pulmonary resuscitation (CPR) until paramedics arrived.

67. There is a slight variation in some of the times given. The first nurse noted that she was called at 7.35am. According to the communications room log, the ambulance was called at approximately 7.42 and arrived at around 7.50am. They further attempted resuscitation, but paramedics pronounced the man dead at 8.05am.

68. Contingency plans were activated. As part of this, the man's next of kin was identified and a family liaison officer appointed. The family liaison officer, together with a governor, travelled a considerable distance in order to break the news in person.

69. The man's family was particularly grateful for the assistance of the family liaison officer. They were especially grateful for her help with arranging the funeral, and visiting them with the man's belongings.

ISSUES

Clinical treatment

70. A clinical review was carried out by a multi-disciplinary panel of professionals. (Some members of the panel had been involved in the man's care, others had not.) Many of the findings are outlined in this section of my report. However, I urge the governor and head of healthcare to consider all the issues raised in the full review.

71. Although young, the man had a history of cardiac problems and had suffered a myocardial infarction (heart attack). He was inconsistent in taking medication (this was mainly for his heart problems). He was also prescribed anti-depressants and anti-psychotic drugs.

72. The clinical review concluded that:

> "The man's physical health care was monitored by the Primary Care Service. Treatment for cardiac problems – evidence clearly indicates that the man took his cardiac medication only intermittently. He had regular BP [blood pressure] and other routine checks done. It is possible this refusal of his medication was another method of self-harming. He was offered an appointment with an external specialist which he declined. He could not though be forced to take his medication."

73. I endorse the following recommendation from the clinical review:

> **Where a prisoner refuses to take his medication, external specialist advice should be sought (where relevant) to advise on impact of the refusal and any mitigating steps which can be taken to alleviate negative effects.**

74. Two sets of clinical records are kept for each prisoner, one set in the DSPD and another in central healthcare. This clearly does not provide a cohesive set of notes across healthcare professionals, particularly if primary care staff are dealing with health concerns that are not psychiatric problems. Although this was not a big issue in the care of this man, it is possible that in some instances combined records would be more beneficial.

75. The man was seen and assessed regularly by the lead psychiatrist, and by psychologists, therapists, mental health nurses, and nurses. His issues and presentation were discussed at every weekly multi disciplinary team meeting. Staff had tried a number of different methods, including different medication. In spite of this, the man was still erratic and demanding. He harmed himself, and damaged property. He also exhibited sexually disinhibited behaviour. In May, after a number of other options had been tried, the lead psychiatrist decided on a trial dose of depot medication. In interview with my investigators, The lead psychiatrist said:

> "[The man] continued to self-harm and he was also repeatedly destructive and he destroyed, smashed property and I think four successive cells. There had been previous damage to property but it had never been, there had never been a pattern of just one after another and another. That had a huge impact on the wing because every time that happens then the prisoners have to be locked away … It had got so bad that he was moved to the Segregation Unit and discussed with staff and we decided at that point that we would talk to him about the possibility of his having an injection of depot medication, not because we thought he was psychotic but because it is a recognised approach to dealing with, managing severely disturbed behaviour. I approached him about that … and talked to him about it again and he agreed that he would try it."

76. As noted earlier, at first there appeared to be no side effects. The initial dose was very small and they waited five days before giving a second dose. The lead psychiatrist explained that any side effects would normally appear within five days.

77. Once he had the injection, his self-harm dramatically reduced and he stopped talking about his index offence. However, he became distressed about the side effects. Many staff and prisoners reported a clear change in him after he took the medication. At first he seemed restless and felt the need to keep moving. The clinical review says:

> "Following this he developed akathisia which continued for approximately ten weeks. He was given medication for these side effects. From this time he no longer talked about his offences or his victim and focused on his physical symptoms. VH [The lead psychiatrist] felt the side effects were genuine and confirmed that such side effects are not unknown though they usually reduce after two weeks.
>
> "The side effects persisted and the depixol injection was discontinued. He was prescribed amisulpride. He continued to be restless and deteriorated appearing at one time to be almost catatonic showing no ability to self care. During this period he needed prompting to do anything including eating and drinking. Gradually this behaviour ceased, the amisulpride was discontinued and he was commenced on carbamazepine and prozac. VH believed him to be highly sensitive to the medication.
>
> "Due to concerns about the side effects VH made a referral to a consultant neurologist who after examining him detected neither physical abnormality nor impairment of memory.
>
> "Some staff were suspicious that he was exaggerating or putting on the symptoms as they felt that when he was not being observed the symptoms appeared to desist. VH emphasised that she did not believe

he was putting it on initially, although at times there did appear to be an exaggeration of the symptoms."

78. The man's reaction was uncertainly unusual. The staff on the DSPD are experienced and were confused by his presentation. The lead psychiatrist explained to my investigators:

> "None of us has ever come across anybody who has had as extreme a reaction, as prolonged a reaction and this total and sustained change in presentation. We concluded that his distress instead of being expressed in all the self-harm was now being expressed in his somatic symptoms and that's the best explanation that we've been able to come to and in retrospect I haven't come up with a better explanation. That in the community he used alcohol to cope with distress, when he was first in prison he used a lot of self-harm and quite dramatic behaviour and that then from the time in April and April onwards that it was in these somatic symptoms.
>
> "…[I thought in] maybe June, July you know this is a very unusual presentation, how can we take it forward, should we get a second opinion, a second psychiatric opinion, should I ask one of my colleagues because there are other psychiatrists that come to the prison? Actually it's quite difficult, he could give a coherent account of what's happening but it's actually the overall picture not just what you get in a one-off interview that was actually really quite important in making an assessment. So I thought it wasn't clear that there was going to be a great deal to be gained by getting a sort of hour's assessment done. So I had in mind at what point should we think about referring him to hospital with the idea that it would have to be his local Medium Secure Unit and Medium Secure Unit with an appropriate level but knowing that he would not be at all a typical case for admission to a Medium Secure Unit, but I thought well at least if they were to come and assess him then they might have a different view and in the longer term it would be likely that they would need to be involved in his final care."

79. The man was aware that consideration had been given to him attending a psychiatric hospital. A nurse said that he seemed comfortable with the idea of going to hospital. The nurse explained that, although the environment would be different, the work that he would be involved in would be the same. The lead psychiatrist had written a letter of referral but it was not sent before the man died.

80. The man's therapist told investigators that:

> "He [the man] was always extreme but the ways that he was extreme changed so he would be, could be extremely aggressive, could be extremely passive, he could be extremely penitent but the ways he was extreme changed and he presented in lots of different ways while he was, certainly since I knew him. But what he would actually say and

> the level of despair that he was actually feeling didn't really change, just the way that he dealt with it changed. Sometimes he would be aggressive to others and sometimes he would be more aggressive towards himself by attacking himself or starving himself and sometimes, he was just totally passive. All he would do was smoke and lie on the bed and you couldn't move him, you just couldn't actually get him out of his cell. He presented in very extreme ways but in very different ways but it was the severity of the presentation that was consistent."

81. Overall, the care given to him was well considered. Actions were taken to address concerns as they were raised and he was constantly supported and monitored by a multi-disciplinary team of nurses, psychologists, a therapist and psychiatrist. (It is important to understand that the DSPD is quite different from the normal prison environment, with a large number of specialists and trained professionals on hand.)

ACCT

82. Whitemoor's safer custody policy complies with Prison Service Order 2700, *Suicide and self-harm prevention*: "Personal items including shoelaces and belts must not be removed from at-risk prisoners as a matter of course. The reasons for the decision to remove or return items must be recorded in the prisoner's ACCT." I support this policy. However, where a prisoner repeatedly uses razor blades to self-harm, consideration should be given to allowing use only under supervision, or restricted in-possession use.

83. The man's ACCT was closed on 16 October. He attended with his personal officer and the first nurse. The content of the review at first appears alarming. The man said he did not want to self-harm. He wanted to die, but was physically unable to kill himself. The SO, who chaired the review, described the meeting to my investigators:

> "He was very talkative. I mean I remember putting in that he is always saying he wants to kill himself. One of the things, he had always said that but then you would say 'do you mean that' and he would say 'no I don't, I'm not capable of killing myself, I don't want to.' It was something he has always said, it will probably appear on a lot of things but when asked it was just an attention thing and asked bluntly was it and he would say 'yes', he had no intention at this time and in fact he had even stopped self-harming."

84. The SO said there was still a care plan in place to inform staff how best to approach him and respond to his behaviour. As such, he would still be monitored and have a high level of staff interaction. The SO also said that he explained to the man that the ACCT could be re-opened at any time. His personal officer felt that the ACCT had been a useful tool in managing him, in that he knew someone would regularly come to talk to him even if

he was locked in his cell. The ACCT had been closed before, sometimes with an interval of a few weeks before being re-opened.

85. His personal officer recalled that he had said that no one understood him, and he felt paralysed. At the review, he had also said he was not going to do anything "silly" or kill himself and that he wanted help with his medication. Along with other staff, his personal officer told my investigators that, although the man self-harmed, there had never been a serious intention to kill himself. Wing and clinical staff spoke with him daily. Indeed, a number of staff told my investigators of their detailed interactions with him, attending him night and day. Prisoners confirmed that staff had been attentive.

86. Even with hindsight, the personal officer thought the decision to close the ACCT was reasonable. He said:

> "I mean if you look at it you could think to yourself, well he is still threatening to kill himself, but I think at the time his mood had improved. He stated before that he wouldn't have done anything, he felt better, he was stating to staff that he couldn't get his body moving but he would be walking up and down the landing no problem whatsoever and talking to some of the other inmates on the spur. At the time I can remember them saying he seems to be a lot better within himself, it's taken time but he seemed to be better."

87. My investigators asked staff whether they felt there was a possibility that they had become fatigued with him, and accustomed to the things he had been saying. The personal officer responded that it was important to make decisions as a team as the man's presentation could change. After the closure of the ACCT, the man had a follow-up interview in which he expressed no new concerns.

Night of 18 to 19 November

88. On the evening of 18 November, the man called a prison officer several times. The first was to ask for toilet roll. The second time he asked the prison officer for some spellings. These were 'anxious', 'distressed' and 'slip'. The officer asked whom he was writing to, and if he was alright. He replied he was okay and was writing to his therapist. A note addressed to his therapist was found after the man's death. In the note, the man thanked him for his support but said he could no longer cope.

89. With the benefit of hindsight, we can understand the importance of the three words the man asked to spell for him. However, he had written letters on almost a daily basis. Indeed, he was encouraged to write about his thoughts and feelings. Other staff felt it was not uncommon behaviour for him. In fact, the sixth prison officer actually said he would have been pleased to know that he asked for spellings as it would mean he was writing again. Later that evening, at 10.43pm, the man again spoke to the

first prison officer, warning her not to check on him for a while as he was about to strip wash.

90. The second prison officer was in charge of conducting the roll check of all prisoners on green spur throughout the night of 18 -19 November. He told my investigators that he conducted the roll check during the course of about an hour, whilst also checking category A prisoners. He believed that the time he checked the man's cell was between 4.10 and 5.15am. His cell was located between two category A prisoners and he checked them at the same time. The times that the prisoners either side of him were checked were logged by the officer and recorded in the category A check log. The entries closest to the time the officer gave are: 3.31 and 3.35am, then 5.20 and 5.23am.

91. The second prison officer told my investigators that the observation panel in the man's cell was blocked at this time. As a result, he could not make visual contact. He said he did not attempt to get a verbal response from him, but he was sure he had heard him moving.

92. When the man was found at approximately 7.30am, there were clear signs of rigor mortis. This usually develops between four and ten hours after death, although it is dependent on a range of factors including the ambient temperature and body mass of the individual. However, it seems unlikely that he could have been moving around his cell when the second prison officer says he heard noises. It may be that the noises the officer heard were actually coming from elsewhere.

93. In any event, the night orders are clear. When conducting a roll count, the officer conducting the count must make visual or verbal contact with every prisoner. During the investigation, my investigator raised this issue with the governor of Whitemoor who subsequently launched an enquiry into the second prison officer's action on the night of 18/ 19 November. Whatever the outcome of that investigation, I think the following recommendation would be prudent:

The governor should remind all staff of the importance of making visual or verbal contact with every prisoner when conducting a roll count.

Crisis management

94. Whitemoor has clear instructions on staff entering cells during patrol state. Staff made attempts to get a response from the man, and acted in accordance with local policies in asking for permission to open the cell door at that time of day.

95. When they entered the cell and found the man, two officers supported his body whilst another officer ran to collect the anti-ligature scissors from a box in the office. Prison Service Instruction (PSI) 32/2006 requires all prisons to ensure that anti-ligature knives are carried by frontline staff. In

some cases, the carrying of knives can save crucial seconds. The PSI came into effect on 20 November and Whitemoor had already stocked the ligature knives in order to implement the instruction. In this case, it would not have affected the outcome. However, in an investigation into a subsequent death at Whitemoor, it came to light that there had been a delay in the implementation of the instruction on anti-ligature knives. The knives have since been issued.

96. The healthcare staff were aware they were running to a person found hanging. They did not take the defibrillator machine with them but, given the weight of the equipment they were already carrying, they could not reasonably have been expected to carry one. However, in some cases, the quick use of a defibrillator can save lives.

97. There was some confusion between the nurse and wing staff over who should call for an ambulance. The head of healthcare was clear that any one can call for an ambulance. However, in Whitemoor's "Death in custody, senior officer action sheet" it says: "On instruction from healthcare staff, call an ambulance (via 999) and duty doctor." Although this did not lead to a delay in getting care for the man, other situations may arise where this confusion could cause unnecessary delays.

98. When the man was found it was clear to all staff that rigor mortis had set in. The first nurse commenced CPR until paramedics arrived. Whilst some clinical staff feel they would like to try CPR in such instances, it can be argued that this is both disrespectful to the deceased and very difficult for staff.

99. PSO 2700 requires that, where there is clear evidence of rigor mortis, resuscitation should not be attempted. Whitemoor's healthcare policy complies with this. However, again there are conflicting instructions to staff. Whitemoor's "Death in custody first on-scene action sheet" reads: "If the prisoner is not breathing, attempt resuscitation unless rigor mortis of the limbs has clearly set in (rigor mortis is a condition of extreme stiffness affecting the arms and legs after death, making it virtually impossible to bend the wrists, elbows or knees)." Conversely, the prison's "Death in custody, orderly officer preservation of evidence action sheet" says: "Primary first aid will be given until such time as a doctor confirms death." All the issues relating to the action sheets, and emergency procedures were conveyed to the governor at the time of the investigation.

The governor should carry out a review of emergency procedures, with particular attention to ensuring that instructions and procedures are consistent. The outcome should be conveyed to all staff to remind them of their responsibilities when responding to emergencies.

100. Furthermore, I concur with the clinical review, that:

There should be a review of the emergency response from clinicians, in terms of the equipment available. Consideration should be given to making defibrillators and emergency equipment available at strategic places in Whitemoor. The review should include appropriate training (including regular update training) for staff in defibrillator use.

Beds

101. The man had turned his bed upright. He then used this both as a barricade to his cell door, and a ligature point. This was discussed with the governor at the time of the investigation. Work has begun securing the beds to the floor, and anticipate that all beds will be been bolted to the floor to prevent them being easily moved by the end of this year. In the meantime, anyone deemed at risk, is located in a cell with a secured bed.

The significance of birthdays

102. Given that the man's death occurred on either his birthday, or the day after, my investigator asked the Prison Service's Safer Custody Group if there was any correlation between the date of someone dying and their birthday. They told me that between 1978 and April 2007, there had been six apparently self inflicted deaths in prisons on the individual's birthday. A review of cases where deaths had occurred several days before or after a birthday was also conducted. The overall finding was that there is a slight increased risk around a prisoner's birthday. However, there are far more significant risk factors. Moreover, there may be a number of significant dates for an individual - anniversaries, the date a loved one died, their sentence date, etc - many of which will be unknown to staff.

Staff, communication and relationships

Support for staff

103. Many of the non-discipline clinicians who work in the DSPD unit belong to professional bodies and they are obliged to receive the appropriate level of supervision designated by that body. In addition, as detailed in the D wing protocol on individual therapy, all clinicians offering individual therapy should receive clinical supervision from a qualified psychologist or psychotherapist at least once every fortnight. The investigation team was told that the current monthly external clinical support available to the unit's psychotherapists (of whom there are three) is to be withdrawn, although clinical supervision is still provided by other clinicians on the unit. The investigation team spoke to several members of non-discipline staff about the levels of support they received. The majority spoke favourably of the supportive nature of the unit.

104. The support and supervision service available to discipline staff on the DSPD unit is still being developed. An SO explained that there is currently an ad hoc system in place for getting clinical supervision, although staff do

have access to external counsellors, known as “Care First”, for a support session every four to six weeks. One of the governors also told the investigation team that, during 2006, systems had been developed to provide operational staff with clinical supervision and senior officers were being trained to enable them to deliver this support. He said that, as the unit’s manager, he personally felt that there was strong peer support on the unit and that the clinicians were available if he needed their support. Certainly, there was a great deal of support offered to both prisoners and staff after the man’s death.

Relationships between staff

105. The Integrated Multi-disciplinary Treatment Model for the DSPD Unit, HMP Whitemoor (March 2006), acknowledges the potential for conflict between discipline and clinical aims of the unit. In the first three years of the unit’s existence, the discipline staff were not aware of the details of the treatment model. The unit focused exclusively on assessing prisoners as the treatment component of the programme had not yet begun.

106. The introduction of ‘treatment’ proved to be problematic in terms of discipline staff adapting to a treatment model. As mentioned earlier, the uniform staff had a shared sense of a broader purpose, however there was no clarity as to how this was to be achieved in the medium and longer terms. There was awareness that the work of the DSPD unit would grow increasingly clinical, but it was unclear how the discipline staff’s role would adapt to accommodate this process.

107. Up to this point in the DSPD unit’s development, the discipline staff had achieved significant success in reducing problematic behaviour with this challenging prisoner group, by applying a management model to the care of the prisoners. Running parallel to this process, the clinical team was developing an increasingly treatment-orientated programme. The Integrated Multi-disciplinary Treatment Model for the DSPD Unit HMP Whitemoor (March 2006) says: “It should be of no surprise that tension developed between both these models and the professional groups that championed them. It is well established that while a management model and a treatment model are not mutually exclusive, they do act in significant tension to each other.”

108. Generally, my investigators found that the clinical and discipline staff worked together well. This was particularly demonstrated in the care that the man received. However, there were some tensions between discipline staff involved in running the therapeutic group work and those that were not. It was clear that some staff felt that they were not as involved in the running of the unit, or as aware of individual needs of prisoners, if they were not involved in group work. My investigators found that there was in fact, a large amount of information sharing available.

Communication and information flow

109. Information about prisoners was gathered by many members of staff across each of the disciplines. In an environment where all the prisoners have complex needs, the effective management and sharing of this information is crucial.

110. Information about prisoners on the unit is recorded and shared in several different ways. Integrated case notes are written for each prisoner with entries made by discipline, clinical and psychology staff. These notes document significant contact between the individual and others on the wing, and are available to all staff on the unit. Clinical staff also record information in the prisoner's medical records. Notes and observations about individuals may be entered in the relevant observation books on each spur.

111. Three briefing sessions (one at the start of each shift) and three de-briefing sessions (one at the end of each shift) are held everyday. This is an opportunity for staff across all disciplines to share information about individual prisoners, including any specific concerns.

112. In addition to these regular briefings throughout the day, each of the unit's spurs holds a weekly multi-disciplinary meeting. They are chaired by a principal officer or senior officer and the minutes are available to staff across all disciplines. At these meetings, staff explore a variety of issues, including operational matters and whether any prisoners are in crisis or on open ACCT forms. The meetings are also used to discuss prisoners with urgent care needs and to develop strategies for how to manage them. The man's individual therapist, told the investigation team that the deceased was frequently discussed at these meetings. My investigators were told that some discipline staff were encouraged to attend. However, it was clear from the minutes that they did not always take up the offer to participate. Where possible, it is clearly right that representatives of wing staff should attend, preferably on a rota basis, to encourage involvement from a range of staff and to spread the learning. That said, on the whole, my investigators judged that good systems of communication were in place and were well used.

113. I conclude that the treatment that the man received at Whitemoor from the multi-disciplinary team was of an extremely high standard. A large number of individuals spent a great deal of time with him during his stay in the DSPD unit.

RECOMMENDATIONS

1. Where a prisoner refuses to take his medication, external specialist advice should be sought (where relevant) to advise on impact of the refusal and any mitigating steps which can be taken to alleviate negative effects.

2. The governor should remind all staff of the importance of making visual or verbal contact with every prisoner when conducting a roll count.

3. The governor should carry out a review of emergency procedures, with particular attention to ensuring that instructions and procedures are consistent. The outcome should be conveyed to all staff to remind them of their responsibilities when responding to emergencies.

4. There should be a review of the emergency response from clinicians, in terms of the equipment available. Consideration should be given to making defibrillators and emergency equipment available at strategic places in Whitemoor. The review should include appropriate training (including regular update training) for staff in defibrillator use.

The Prison Service has accepted all the recommendations.