Investigation into the circumstances surrounding the death of a man whilst a prisoner at HMP Haverigg in October 2007

Report by the Prisons and Probation Ombudsman for England and Wales

May 2008

This is the report of an investigation into the death of a man at HMP Haverigg in October 2007. The man who was aged 26 and serving a relatively short sentence, was found hanging in his cell during the early morning roll check. He had used a bed sheet as a ligature, attached to a curtain pole fitting. My investigators and I would like to offer our sincere condolences to his family, his partner and friends for their sad loss.

Three investigators from my office have investigated the man's death. They have been assisted by Cumberland Primary Care Trust which carried out a clinical review on my behalf. I am grateful for its assistance. I also wish to thank the Governor and his staff at Haverigg for their help and cooperation during this investigation.

The man who died had been at Haverigg on an earlier sentence. After being sentenced on this occasion, he asked staff at HMP Preston if he could return to Haverigg. At no stage during this sentence was he ever considered to be at risk of suicide or self-harm. He had previously been identified as having mental health problems, but on this occasion they were not apparent.

In October 2007, the man was transferred to Haverigg. He gave staff the impression that he was happy to be at the prison and was looking forward to being released shortly before Christmas. However, he was experiencing difficulties in his relationship with his partner. This was known to other prisoners, but was not something of itself that would have warranted monitoring and support under the Prison Service's suicide and self-harm monitoring procedures.

Stephen Shaw CBE
Prisons and Probation Ombudsman **May 2008**

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SUMMARY

The man who is the subject of this report was sentenced to 160 days imprisonment at the Magistrates' Court in October 2007. He was taken to HMP Preston where he remained until being transferred to HMP Haverigg on 25 October. He had been to Haverigg on a previous sentence and had asked to go there again. However, it would appear that the transfer should not have taken place on 25 October as the man had an appointment at hospital for a brain scan that same day. He told staff that the scan had been arranged after he had had a fit earlier in the year.

When he arrived at Haverigg, the man was allocated to the prison induction unit as part of the normal procedure for arriving prisoners. Although he had been at Haverigg previously, he was still required to undergo assessment in the induction unit and appears to have settled in well. However, on the evening before he was found dead, he had been overheard arguing with his partner on the telephone and appeared to be upset. Although fellow prisoners knew he had had a disagreement with his partner, it was not sufficiently serious to warrant him being monitored and supported under the Prison Service's suicide and self-harm procedures, and no concerns were raised about what he might have been planning to do.

During a routine morning roll check on 28 October, the night patrol looked into the man's cell at about 6.20am and saw him hanging from a ligature attached to a window fitting. The night patrol officer summoned assistance and waited for support to arrive before entering the cell. Sadly, when assistance arrived it was apparent that the man had died. Rigor mortis was present, making any attempt to resuscitate him impossible.

THE INVESTIGATION PROCESS

1. This investigation was formally opened at Haverigg on 31 October 2007 by one of my investigators. The Deputy Governor and his staff provided the man's core record and a number of other documents for examination. My investigator met with a member of the chaplaincy and a representative of the Prison Officers' Association. Although my investigator did not meet with a member of the Independent Monitoring Board at the time of opening the investigation, arrangements were made to meet a representative of the Board on a future visit.

2. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone with relevant information to make themself known. As a result, one prisoner asked to speak to the investigators. My investigators were also given unrestricted access to the prison, staff, prisoners and documentation relating to the man who died, including his medical record. Cumberland Primary Care Trust (PCT) was given the medical record and carried out a clinical review of the man's care and treatment whilst in custody.

3. One of my family liaison officers contacted the man's family inviting them to contribute towards my report. The family raised one question relating to his medication which my report has been able to answer. Unfortunately, I am unable to answer the main question which is why the man apparently decided to end his life.

4. My investigators wrote to Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, a copy of this report will be sent to the Coroner to assist in his enquiries into the man's death.

5. The following prisoners assisted my investigation by providing background information:
   - Prisoner A transferred to Haverigg with the man who died from Preston.
   - Prisoner B is a prisoner at Haverigg who also travelled with the man who died when they transferred from Preston.
   - Prisoner C has been a prisoner at Haverigg for 11 months. He is employed as a wing cleaner and prepares the cells in readiness for the arrival of new prisoners.
   - Prisoner D.
   - Prisoner E has been a prisoner at Haverigg since September 2007 and first met the man who died on 27 October.
   - Prisoner F.

6. The following staff have also contributed to my investigation:
   - An Acting Senior Officer (ASO) who had known the man during a previous prison sentence provided background information.
   - A Senior Officer (SO) who was the night manager on duty on 27 October.
   - An Operational Support Grade (OSG) who was the night patrol who found the man hanging.

- An officer who has been employed at Haverigg for six years. He assisted other staff in cutting the ligature when the man was found.

7. On 29 February 2008, my investigator received the clinical review from the PCT. The report raised a number of issues that the investigator felt necessary to share with the Governor. In turn, the Governor wrote to my investigator on 5 March offering his comments on the review. I am very grateful for his prompt response and have summarised his comments in the clinical review section of this report.

HMP HAVERIGG

8. Haverigg is an adult male category C prison. It is situated two miles outside the small town of Millom in West Cumbria. The prison occupies an old Royal Air Force (RAF) airfield at the foot of the Lakeland Hills. Haverigg opened as a prison in 1967 and some of the accommodation which was used by the RAF is still in use in the form of single storey dormitory units. Some modernisation has taken place when further accommodation units has been added.

9. The living accommodation is divided into four residential zones. Residential unit one (R1) is a purpose-built cellular house block with two wings (A and B), each housing 60 prisoners in single cells with integral sanitation.

10. Residential unit two (R2) comprises nine cellular billets with single and double rooms, all with integral sanitation. The unit accommodates 196 prisoners. Residential unit three (R3) includes seven billets with mainly single rooms, and houses 126 prisoners. Residential unit four (R4) comprises 40 rooms in a ready-to-use unit, all with ensuite showers. All rooms have in-cell television.

Code blue and code red

11. In the event of urgent medical assistance being required, the prison has a radio code system to alert medical staff to the emergency situation. Code red informs staff that the patient is bleeding. Code blue alerts them that the patient is in breathing difficulty. The system ensures that staff take the correct emergency equipment with them to an emergency and so provide the necessary medical care as quickly as possible.

Healthcare provision

12. Cumberland PCT provides the primary care provision to the prison. It is a Type 2 healthcare service, which is similar to a doctor's service in the community. Healthcare is open between 8.00am and 5.00pm Monday to Friday, with an on-call doctor available for out-of-hours support. There is a nurse available in the prison over the weekends, working similar hours to that available during the week. The staffing levels are:
    - Head of Healthcare
    - Four full-time registered general nurses
    - One full-time Registered Mental Health Nurse (RMN)
    - Two administration officers.

    The prison has the support of a visiting psychiatrist who attends by referral from the RMN. Additionally, healthcare staff have access to a dentist, optician, dietician and physiotherapist.

Her Majesty's Inspectorate of Prisons

13. Haverigg was most recently inspected between 21 and 23 August 2006, when HM Chief Inspector of Prisons, Ms Anne Owers, carried out an unannounced short follow-up inspection of the prison. In her introduction to the inspection report, Ms Owers described the prison as an essentially safe and respectful

establishment, with reasonable levels of activity and improving resettlement arrangements. Ms Owers wrote as follows:

> "Since our last inspection in 2003, Haverigg had continued to improve arrangements to ensure prison safety. First night officers, supported by Listeners now saw all new prisoners. Anti-bullying procedures had been revised and the separation and care unit had been refurbished. However, it was disturbing that while instances of self-harm were low, suicide and prevention procedures were poor and under resourced. Poor perimeter security, a sprawling site and limited staffing meant that drugs, alcohol and mobile phones remained a perennial challenge.
>
> "Staff-prisoner relationships remained relaxed and mutually respectful, supported by an improved personal officer scheme."

14. Ms Owers concluded by saying:

> "Overall, staff and managers at Haverigg deserve congratulations on the progress they have made. There is still plenty to do but, particularly given the challenge of the prison's location and the inadequacies of its site, it is commendable that Haverigg is performing reasonably well against all our tests of a healthy prison."

15. The inspection found that first-night arrangements had improved, with all new arrivals being seen by 'first-night officers'. The Chief Inspector's report added that there was a 'rolling' induction programme that included key components, but there were too many gaps and, as a result, prisoners were spending too much time locked in their cells. Listeners saw new arrivals in reception and they supported the induction process.

Induction

16. All prisoners arriving at Haverigg are initially allocated to the induction unit. This is where their individual needs are assessed by prison staff and they are introduced to the facilities and regime available. During the induction period, prisoners are allocated to a place of work which they join once they move onto the residential unit to which they are allocated.

17. An important part of life for a large proportion of prisoners at Haverigg, especially the younger men, is the gymnasium. For this reason, during the normal induction period, gymnasium staff offer their own induction session to any prisoner wishing to use the facilities. It is only after the gymnasium induction has been completed satisfactorily that prisoners are allowed access to the gym.

Listeners

18. The prison has a Listener scheme under which the Samaritans train selected prisoners to be the first point of contact for any prisoner who is feeling vulnerable or at risk of harm. The scheme is confidential and any prisoner can

request to speak to a Listener at any time of the day or night. Prisoners can easily access a Listener by speaking to a member of staff. The staff then make the arrangements for a trained Listener to speak to the prisoner concerned. During the hours that prisoners are locked in their cells, anyone wishing to speak to a Listener can make a request to the night staff on duty. The Night Orderly Officer has the authority to unlock a Listener and to escort him to the cell of the prisoner who is requesting assistance.

Night patrol

19. Cells are not usually unlocked during night state unless the night manager has sufficient staff resources in place to deal with the situation. Night patrol staff do not carry security keys and are therefore unable to move freely around the prison. However, they do carry a cell door key in a sealed pouch that is secured to their uniform belt. In the event of a life-threatening situation, and when it is felt necessary to enter a cell, the night patrol officer breaks the pouch seal to obtain the key. However, the officer must summon assistance and should only enter a cell alone if it is safe to do so.

20. Unlike the night patrol staff, the night manager does carry security keys and is able to move freely about the prison. The manager will usually visit the wings at points during the night to check on the welfare of the staff and ensure they are carrying out their duties correctly.

Personal issue cut-down tools

21. Personal issue cut-down tools are given to uniformed staff. The tools are designed to allow the user to get underneath a ligature without cutting the person found hanging. Once underneath, the user can safely cut the ligature from around the neck.

Prison officer grades

22. There are three levels of uniformed prison officer grades. Prison officers are the front-line supervisory staff and, in the majority of cases, prisoners have first and most contact with them.

23. Senior Officers (SOs) are the first grade of managers and act as a reference point for prison officers. SOs are responsible for the day-to-day management of their area, supervising staff and dealing with issues raised by prisoners.

24. Principal Officers (POs) are the highest rank of the uniformed staff. They supervise other uniformed staff and have operational responsibility for the prison.

25. The orderly officer is the duty manager, and is often referred to by the radio call sign ‘Oscar’. During the day at Haverigg, the duty manager is a PO, but at night the duty manager is an SO.

26. Officer Support Grades (OSGs) wear prison uniform and carry keys but do not carry out the same function as prison officers. Their role is to support the areas of the prison that have little or no prisoner contact, for example, the gate. Additionally, OSGs perform night duties and are responsible for patrolling the wings. Should they require assistance, they contact the night manager in the first instance or an officer.

Roll checks

27. Roll checks are carried out in order to confirm that the number of prisoners on each wing corresponds to the total number in the prison. When the roll is checked, the officer must see that the prisoner is in their cell. However, they are not required to confirm the prisoner is alive. The reason for this is that some roll checks are carried out very early in the morning and it is considered inappropriate to wake the prisoner. However, if the prisoner is subject to suicide and self-harm monitoring and support procedures, the officer must confirm that the prisoner is alive. During routine roll checks, if the officer has any doubt about the condition of the prisoner or is unable to see the occupant of a cell, they must seek assistance immediately and if necessary enter the cell.

Suicide and self-harm monitoring

28. At the staff entrance to Haverigg, there is a notice board listing the names, location and photographs of all prisoners being monitored under the Prison Service's suicide and self-harm procedures (Assessment, Care in Custody and Teamwork, known as ACCT). The information is readily available to all staff working at the prison, is updated as necessary and keeps everyone informed about those prisoners at risk of harm.

KEY FINDINGS

29. The man who is the subject of this report was remanded into custody by the Magistrates' Court in October 2007. After being remanded into custody, he was taken as an unconvicted prisoner to HMP Preston where he underwent the normal reception procedures before being taken to his cell. During the routine reception health screening, the man was asked if he had ever attempted suicide or had any suicidal thoughts. He said he had not. The nurse who carried out the health screening noted that he said he was waiting for plastic surgery on his nose and ear (which he said had been bitten during a fight some time previously). Additionally, it was noted that the man had a pre-arranged appointment for a brain scan which was scheduled for 25 October. He said the scan was arranged after he had had a fit earlier in the year.

30. Four days after being remanded into custody, the man returned to the Magistrates' Court and was found guilty of the charges against him. Once again he was remanded into custody, but this time as a convicted, unsentenced prisoner. However, due to prison population pressures and there being no cells available at Preston, the man was temporarily held in police cells under the Government's emergency custody arrangements known as 'Operation Safeguard'. He was held under these arrangements overnight but, on the following day, was taken back to HMP Preston where he remained until his next court appearance.

31. Later that same month the man was taken to the Magistrates' Court for sentencing. He was sentenced to 160 days imprisonment and returned to Preston. When he was seen as part of the reception procedures, he asked to be transferred to Haverigg. The reason for the request was to avoid the man who had bitten his ear and who he knew to be a prisoner at Preston. Additionally, he had been a prisoner at Haverigg on a previous sentence and apparently preferred to be there.

32. In the meantime, the prison administration department had received the man's warrant of imprisonment and calculated when he would be released. After taking into account the total sentence, and allowing for the time he had been held on remand, the date of his release was calculated to be 22 December 2007. As part of the normal sentence calculation procedure, he was told of his anticipated release date.

33. On 25 October, the man was due to have the brain scan. However, despite the appointment, he was transferred with four other prisoners to Haverigg to complete his sentence.

34. My investigators identified four prisoners who had travelled from Preston with him and spoke to two of them. (The remaining two prisoners had been discharged by the time my staff went to Haverigg.) Prisoner A said he could not tell if the man was happy to be at Haverigg or not. He remembered that, whilst in the prison reception area at Preston, the man asked prison staff how long it would be before they left for Haverigg. Prisoner A said that, when they arrived at Haverigg, they were held in a waiting room in the reception area. He

said the man was impatient and wanted to know from staff when they would be going to the wing.

35. Prisoner A recalled that, during the induction period, the man asked a member of staff what he was allowed to do during social visits. He apparently wanted to know if his visitor could sit on his knee and was told not. Prisoner A said the man was upset when the officer told him that all he could do was kiss. Although Prisoner A told the investigators that he did not speak to the man much, he said he gave no indication about ending his life.

36. Prisoner B confirmed to my investigators that he travelled to Haverigg in the same vehicle as the man who died. He said that he did not appear to be happy at the prospect of being at Haverigg. Prisoner B added that his only recollection of the man was when they were in the reception waiting room at Haverigg. The man told him that he was having a few problems with his girlfriend, but did not say what the problems were.

37. As part of the normal reception procedures, the man was interviewed by a nurse who completed a reception screening document. Unfortunately, the nurse did not have access to the man's previous prison records as they had been filed away.

38. After being received into the prison and on leaving the reception area, the man and the other prisoners who arrived that day all went to the prison induction wing where all arriving prisoners go. He was allocated to cell A2:3.

39. An ASO interviewed as part of the investigation told my investigator that she remembered the man from a previous sentence he had served at Haverigg. She described him as a 'bouncy' person and as being 'full of life'. The ASO said that her experience of the man was that he would always do what he was meant to do, and that he was polite and caused no problems to prison staff.

40. On the day that the man arrived at Haverigg (25 October), the ASO saw him as she entered the wing where he lived. The man saw her and ran across the wing to greet her. She said that they chatted for a while and the man asked if she could arrange for him to move to a particular wing (R3) once his induction period came to an end. The ASO told my investigators that, although she considered the man to be suitable for R3, she was unable to deal with the move until the next occasion when she would be on duty towards the end of his induction period. Sadly, the ASO did not have the opportunity to make the necessary arrangements.

41. Whilst taking exercise on 26 October, the man spoke to one of the supervising officers and asked if she would get him a pair of prison issue slippers. The supervising officer made a note of his details in her notebook and the following morning she left slippers outside his cell. The man spoke to her later that day whilst on association and thanked her for remembering to get the slippers. She told this investigation that, from what she saw of him, he was a very polite and 'bubbly' young man.

42. My investigators spoke to a number of prisoners to try and gauge how the man behaved during the short period of time he was at Haverigg, and how they felt about the prison. Prisoner C works as a cleaner on the induction unit. He told my investigators that staff on the unit do everything they can to ensure prisoners have access to telephones and anything else they might require. He described Haverigg as a good prison, but said there were lots of instances where bullying was taking place, along with a number of gangs building up. He said that bullying did not happen on the induction unit and that it was mainly confined to one particular unit in another part of the prison.

43. Prisoner C described the man who died as quiet and, on the occasions he had noticed him, he was to be seen talking to other prisoners. He remembered the man asking him for curtains for his cell and for cleaning equipment. Prisoner C said that he and the man had on one occasion spoken at length, but nothing suggested to him that the man was in any way vulnerable or at risk of harm.

44. My investigators asked Prisoner C if he had any first-hand knowledge of how prison staff treated anyone whom they knew to be at risk of harming themselves. Prisoner C said he had seen for himself staff sitting outside open cells all night, monitoring and supporting prisoners who were deemed to be at such a high-risk level. He spoke highly of the level of support available to these prisoners.

27 October 2007

45. Prisoner D told my investigator that during the evening association period he overheard the man arguing with someone on the telephone, and believed it to be the man's girlfriend. He said the argument was about the man's girlfriend wanting to end the relationship and not visiting him. He described the man as being upset during the telephone call, adding that he was crying. Prisoner D said that the man ended the telephone call and returned to his cell. Shortly afterwards, he saw him go back onto the telephone but did not see where he went to after the call ended.

46. Prisoner E said that he too saw the man using one of the telephones the evening before he died and described him as 'looking down'. Despite this, he and the man played pool later that day and there was nothing out of the ordinary in the way the man behaved. He added that no one could have predicted what he was about to do.

47. Prisoner E is a prisoner in the same wing as the man who died. He said that he first met him when he went into a cell where the man and another prisoner were having a cigarette. Prisoner E told the investigation that the other prisoner told him the man had been arguing with his girlfriend on the telephone.

48. Prisoner E went on to say that, once the prisoners had been locked up for the night on 27 October, he overheard the man talking to another prisoner through his cell window. The man asked the other person to wake him the following morning so that he could watch *Match of the Day* on television. Prisoner E said that no one, including staff, knew anything about the man's intentions. He had

previously seen staff monitoring those prisoners who had been identified as vulnerable, but the man who died was not one of them. Prisoner E added that Listeners are always available and that staff will arrange for a Listener if required.

49. The last prisoner whom my investigators spoke to was Prisoner F. He told us he had seen the man on the wing, but had not spoken to him. He said that his cell was on the landing below the one where the man had lived and therefore he could hear him whenever he talked through the cell window.

50. At about 11.15pm on 27 October, Prisoner F heard the man talking to another prisoner about football. From the conversation, he did not hear anything to suggest that the man was in crisis. Once the conversation ended, Prisoner F did not hear anything further from the man's cell. (At the end of the interview, Prisoner F asked my investigator to pass on his condolences to the man's family.)

28 October 2007

51. At approximately 6.20am, a night patrol OSG was carrying out his early morning roll check in A wing. He looked through the observation panel in the door of cell A2:3, which is a single occupancy cell, and saw the man sitting on his bed at the far end of the cell. At interview, he said the man was motionless and looking directly at the cell door. He described how he then noticed that the man had a ligature around his neck, attached to a window fitting. To aid his observation, the night patrol put the cell light on and opened the door with the intention of cutting the man down. However, he formed the opinion that the man had died. Instead of entering the cell or using his prison radio, he went to the nearest telephone to ask for assistance. He returned to the cell and waited with his cut-down tool for other staff to assist him.

52. In the meantime, the night manager, a Senior Officer, and another officer had already begun making preparations to unlock the prison in readiness for the daytime staff coming on duty. They began their work at about 6.00am by unlocking one of the units. They then went outside to continue unlocking the remainder of the prison.

53. The night manager said at interview that he first learnt of the situation when he received an urgent request on his prison radio asking him to go to cell A2:3. He was told there was a code blue emergency in the unit. After acknowledging the radio message, he and the officer went immediately to the unit. Whilst running across the grounds they met two other officers who were also responding to the radio message. The officers were the first to arrive at the cell, quickly followed by the night manager.

54. The night manager said that when he arrived he saw the night patrol OSG inside trying to cut the man down using a cut-down tool. He added that he saw that the man was wearing shorts and in a seated position on the bed, facing the door. The night manager said he took the knife from the OSG and asked the officer who had accompanied him in unlocking the prison to take the man's

weight, so that he could cut the ligature. The night manager supported himself by placing one foot onto the bed and then cut the ligature away from the window frame.

55. The officer who had accompanied the night manager told him that the man was stiff. The night manager told the investigators that it was evident that rigor mortis was present and that the man had, in his opinion, been dead for some time. He said that after cutting the ligature away, the man remained in a seated position on the bed. The night manager considered attempting resuscitation but decided from the condition of the man's body, which he said was 'blotchy', that the man had died. However, as he could not be certain, he contacted the prison control room using his prison radio and asked for an emergency ambulance to be called. He then arranged for prison staff to wait at the gate to meet the ambulance and escort the ambulance staff to the wing.

56. In the meantime, the night manager told the other staff there was nothing more they could do for the man and to leave the cell. Aware that the police would examine the cell to confirm that the death was not suspicious, he wanted to ensure that nothing was disturbed.

57. Whist waiting for the paramedics to arrive, the night manager unlocked the wing doors and gates so that the ambulance would have close access to the unit. When it arrived, the night manager briefed the paramedics about what had happened and took them to the man's cell. The paramedics quickly confirmed that he had died. Like the night manager, they did not move the man but left the cell and waited for the police to arrive.

After the man's death

58. As part of the normal procedure following any death in a prison, the police are asked to attend. In this case, the police are satisfied that there was no one else involved in his death and are not treating his death as suspicious.

59. My investigators have obtained a transcript of the telephone call made by the man on 27 October at 2.51pm. The man told the woman to whom he was speaking that he was happy to be at Haverigg. They argued for a while, but the argument ended with the man telling the woman that he loved her. It is clear that the call had upset him as he said that his 'head would be in bits all weekend'. However, he added that he would write a letter to her on Monday and that he would next speak to her on the following Thursday.

60. After any serious incident in prison it is recommended that a 'hot debrief' is carried out. The purpose of a hot debrief is to obtain, as soon as possible, the circumstances of a particular incident and identify who has been involved. Following the man's death, there was no hot debrief.

61. My investigators asked staff how they felt about the support offered to them by prison management. The majority said they had been offered support or at least reminded about the local staff care team. However, not all of those directly involved felt the same, and they believed that more could have been

done to support them. Those prisoners to whom my investigators spoke said prison staff had told them about what had happed and said they felt well supported.

62. One of my family liaison officers (FLO) contacted the man's mother. She described the contact with the prison since her son's death as very helpful. She said that the prison's own family liaison officer had been to meet her and had attended her son's funeral. I have been pleased to learn that the Governor offered assistance with funeral costs. The man's mother said that, with the exception of letters from her and the man's girlfriend, all of his property had been returned. My investigator has been unable to trace the letters and I therefore ask the Governor to make a further effort to find them and return them to the man's mother.

63. The man's mother stressed to my FLO that she attaches no blame to the Prison Service for her son's death. She added that the man was told he would receive help in the community within seven days, following his last discharge from prison. However, in reality, when he was released he was then told that the waiting list was four years. The man's mother added that no matter how hard he tried to get help, he was faced with waiting lists. The man's mother believes that the waiting list for mental health patients is unacceptable and contributed to his death.

CLINICAL REVIEW

64. In order to review the medical treatment received by the man whilst in prison, the clinical reviewer chaired a multidisciplinary team meeting. Present at the meeting, held on 8 January 2008, were a number of medically qualified staff brought in by the clinical reviewer to assist him in compiling his report. Although the clinical reviewer does not name the attendees of the meeting, he does note that the following grades were present: a nurse manager, a nurse involved in governance, a manager with experience of the prison and ambulance services, a risk manager with experience in the Prison Service, and the prison's healthcare manager who was observing and provided information to the team.

65. The clinical reviewer notes that, when the man first went into prison on 6 June 2006 on an earlier sentence, he told prison medical staff that he suffered from depression and was taking an antidepressant (citalopram). He was referred by the prison to the Mental Health Outreach Team, ostensibly to consider 'anger management', and was then seen and assessed on a number of occasions. The clinical reviewer notes that a specialist registrar to a Consultant Forensic Psychiatrist provided a detailed court report about the man's medical condition. The specialist registrar concluded that the man had suffered a psychotic episode, and had a long-standing history of angry outbursts and a persistence of depressive symptoms which had become worse whilst in prison.

66. Additionally, it was noted by the specialist registrar that the man had a history of alcohol abuse. She also said that he appeared to have had two discrete episodes of severe mental illness and recommended that he continue taking an anti-psychotic drug called olanzapine. As well as taking regular anti-psychotic drugs and antidepressant medication, the specialist registrar considered that the man would benefit from psychotherapeutic input to address issues such as anger, low self-esteem, anxiety symptoms and long-standing obsessive-compulsive symptoms. The specialist registrar added that, if the court were to impose a custodial sentence, it should be noted that the man was a vulnerable young person with depressive symptoms. She advised that any regime should ensure that it could safely manage any risk to him that might arise. In addition, she recommended that mental health interventions should be delivered in custody and followed through into community aftercare.

67. The clinical reviewer notes that the man was assessed by a Community Psychiatric Nurse (CPN) from the Early Intervention Team and also a CPN from the PCT Mental Health Team. He then saw a psychiatrist who decided that the man did not require any psychiatric treatment and was not at risk. The psychiatrist also supported the withdrawal of olanzapine which the man had already stopped receiving. The clinical reviewer does not say when the olanzapine was withdrawn.

68. Prior to being discharged from prison on 4 November 2006, the man was seen by his case managers. The unidentified person making a note in the man's medical record wrote that the Early Intervention Team would visit him at his family home during the following week. It was also noted that he would be

seen by the team psychiatrist to determine what would be his most appropriate path of care in the community.

69. The clinical reviewer met the man's doctor who said that the man's care had been handed over to the PCT Mental Health Team. They decided that the man should be referred to a clinical psychologist. The clinical reviewer suggests that the reason for the referral was to help the man with anger management.

70. The man's doctor told the clinical reviewer that the waiting list was 'unacceptably long'. In the meantime, she decided to refer the man to the alcohol team to help with his 'problem drinking'. The doctor told the clinical reviewer that the man had, on his own volition, stopped taking citalopram by 8 March 2007. The doctor said she was not aware of the man receiving any help from the psychiatric service in the community between his prison sentences.

71. The clinical reviewer and his team carried out a process-mapping procedure to look at the man's latest period of imprisonment when he was remanded into custody in October 2007. From that process, the clinical reviewer has drawn up a number of conclusions.

72. The clinical reviewer says the most important finding was that the man's medical record from his previous period of imprisonment was not easily available on his re-imprisonment. Had it been available, the forensic psychiatric report written by the specialist registrar would have been seen. In discussions with prison medical staff, it was apparent to the clinical reviewer that access to previous medical records is 'extremely difficult' both because of the manner in which they are stored and the inability to locate them. The clinical reviewer makes it clear that the man's previous medical records were not made available until two days before the multidisciplinary meeting took place. Had they been available to the prison medical team, more attention might well have been paid to his vulnerability. The clinical reviewer adds that the lack of access to the man's previous medical record and his 'out of prison' medical notes made his medical care more difficult.

73. The clinical reviewer notes that there is no common, computerised medical record available across the Prison Service. He adds that there is no easy interchange of records across the prison and civilian medical services. However, there is no technical or logistical reason why such transfer could not occur from prison to general medical practice and vice versa. The clinical reviewer also says that the absence of such transfer of information denies prisoners access to complete, holistic and 'joined up' healthcare.

74. The clinical reviewer also comments on the need for first aid procedures at Haverigg to be revisited in terms of current guidance. He says there is no first aid policy in place, but the prison does adhere to a workplace standard and a First Aid Need Assessment has been completed and is updated annually for all areas of the prison. The clinical reviewer stresses that the lack of a policy made no difference in the man's case. Moreover, the first aid guidance is a management issue and not a medical one. The clinical reviewer goes on to say

that Cumberland PCT is to clarify its role, if any, with regard to first aid in Haverigg.

75. Similarly, the clinical reviewer considers the availability and access to a defibrillator and those trained to use such equipment. (Once again he stresses that defibrillators were not a factor in this case.) His clinical review notes that defibrillators provided in the healthcare centre for use by PCT staff are the responsibility of the PCT. He says the defibrillator in healthcare is old and needs replacing. However, he also recognises that there are plans by prison management to provide 'first responder' defibrillators. He adds that the maintenance of them would be a management issue, but in his view the provision of 'first responder' defibrillators is sensible.

76. Due to Haverigg's remote location, my investigators asked the clinical reviewer to consider the local emergency services provided by the Ambulance Service and the primary care out-of-hours service. The clinical reviewer has established from ambulance records that the emergency services were first called to the incident at 6.31am. The ambulance was en route at 6.35am and arrived five minutes later at 6.40am. The overall response time was nine minutes. The clinical reviewer is satisfied that this had no relevance to the man's death.

77. The clinical reviewer says that the provision of mental health services in and to Preston during the man's previous imprisonment appeared adequate, and indeed better than those he received outside of prison. The clinical reviewer adds that it was unfortunate that the Early Intervention Team declined to follow the man up on his discharge from prison without assessing him further, on the grounds that he was not psychotic or seriously mentally ill. This was despite the report produced by the specialist registrar.

78. The clinical reviewer comments further on the man's mental health problems. He says it had been agreed with the man and by the prison psychiatric services that he would benefit from help with anger management. The clinical reviewer adds that, given the eventual outcome, it was unfortunate that such services could not be accessed in a timelier manner.

79. My investigators asked the clinical reviewer to comment on the man's medication. He says it is clear that the man voluntarily stopped taking his antidepressant medication when discharged from prison. However, he adds that it was more significant that a prescription for olanzapine was stopped during his previous imprisonment. It was clear from the man's medical notes that it had not been understood that the olanzapine had been prescribed as a preventative medicine and not to treat any current psychotic symptoms. As a consequence, the clinical reviewer believes the man should have been encouraged to continue with his medication.

80. The investigators also asked the clinical reviewer to examine why the man was transferred to Haverigg on the day he was due to have a brain scan, and what injections he was due to receive. It is clear that the man had made the request to transfer to Haverigg. The clinical reviewer says that the prison

documentation is ‘poor’ and there is no clear evidence to show why the man’s transfer could not have been delayed or whether such a delay had been considered. The clinical reviewer points out that the transfer was against Haverigg’s own admissions policy of not taking anyone whose medical investigation was incomplete. As before, the clinical reviewer stresses that, in his opinion, the transfer to Haverigg and failure to access the brain scan had no bearing on the man’s death.

81. With regard to the injections, the clinical reviewer has identified them as steroid injections. He says the injections were for the treatment of a painful shoulder and that it was the man who did not keep the appointments. The clinical reviewer is satisfied that this had no relevance to the man’s death.

82. After sharing the clinical review with the Governor my investigator received a written response to the points raised by it. The Governor said that he had been assisted by the head of healthcare. The following points are a summary of what he said in his letter:
    - In relation to information technology (IT) incompatibility between the Prison Service and the PCT, the Governor says this is due to prisons working with different PCTs. He adds that recent national problems with Prison Service IT and National Health Service (NHS) IT individually suggest that an early solution is not possible.
    - With regard to first aid, the Governor is looking to introduce a system where the names of all trained first aid staff on duty will be held in the prison’s communication office.
    - Three defibrillators have since been purchased by the PCT, which will be sited around Haverigg. Ownership of the equipment has transferred to the prison and it will be the prison’s responsibility to carry out the required checks. The PCT is to provide the relevant training to prison staff.
    - The Governor says it is not clear whether the man’s brain scan appointment had been cancelled or not. He adds that he would not have expected the transfer to take place had it not. He is to raise the issue of the man’s transfer to Haverigg with his Area Manager.

ISSUES

83. At the staff entrance to the prison, there is a notice board listing the names, location and photographs of all prisoners being monitored and supported under the Prison Service suicide and self-harm procedures (ACCT). The information is readily available to all staff working at the prison, updated as necessary and keeps everyone informed about those at risk of harm. I regard this as good practice.

84. Prison Service Order 2710, section 5.3, states:

> 'There must always be a hot debrief immediately after the incident and provision for this should be made in local contingency plans. A senior member of staff must act as debriefer and a duty care team member must also attend.'

Although there were informal checks made by managers, there was no hot debrief after the man's death.

The Governor should ensure that the instructions contained in PSO 2710 are properly followed.

85. The clinical reviewer says there is no common, computerised medical record available across the Prison Service. As a result, there is no easy interchange of records and inter-availability across the prison and civilian medical services. The clinical reviewer explains that it is possible to transfer general medical practice records overnight electronically from one general practitioner (GP) to another, adding that there is no technical or logistical reason why such a transfer cannot occur from prison to GP and vice versa. The clinical reviewer goes on to say that the lack of easy transfer denies prisoners access to joined up healthcare.

86. The clinical reviewer recommends that the Prison Service and NHS investigate with urgency why it is that medical information cannot be transferred more easily and quickly. He suggests that the solution would be for prisoners to be registered with the prison's medical service on a patient/GP basis. The clinical reviewer adds that, with the changes in the way general medical practice is being provided in England, there would appear to be potential for this. He recognises that for this to occur the Prison Service would need to be using a compatible computer system to that used by the NHS and GPs. The clinical reviewer is quite clear that the lack of such a system means that the care of ex-prisoners once back in the community will be impaired by lack of reference to notes made within the prison medical record.

The Prison Service should examine whether it is feasible to provide nationally a computerised system compatible with that available in general medical practice and the NHS.

87. In general, the clinical reviewer feels that attention needs to be given by prison management to the time when prisoners are received into Haverigg. He points out that proper clinical assessment cannot be satisfactorily carried out when prisoners arrive late and makes the following recommendation:

The Governor should ensure that sufficient time is available for all newly arrived prisoners at Haverigg to be given a proper clinical assessment.

88. The man was transferred to Haverigg on the day he was due to have a brain scan. It is not clear from his medical notes why the transfer went ahead or whether any consideration had been given to delaying the transfer. It is not known whether the man consented to the appointment being cancelled. Additionally, it is not clear whether Haverigg knew of the medical appointment. If the prison was aware, then the transfer took place against its own policy of not accepting prisoners with outstanding medical appointments. I am not satisfied that the transfer of prisoners to Haverigg is managed robustly, or that the cancellation of the man's medical appointment was appropriate. I am pleased to note that the Governor is to raise the issue with his Area Manager.

89. The clinical reviewer says that, in his opinion, the relevant issues in this case are whether healthcare staff had the opportunity to adequately assess any increased risk of self-harm and whether he should have been monitored more closely. He is satisfied that the usual procedures were undertaken satisfactorily and additional monitoring was not required. However, he stresses that, had the man's previous medical notes been available along with a proper understanding of the psychiatric assessment, and had the overheard telephone conversation with the man's girlfriend been recognised, then his death might have been avoided.

90. The clinical reviewer ends his clinical report by referring to mental health access in the local community. He says he found that the disposition and availability of mental health services in the local community meant that the man was not able to access the help out of prison that he needed.

CONCLUSIONS

91. The man who died did not leave anything behind to say what his intentions were when he placed a ligature around his neck. There is evidence that he had suffered from depression and had low self-esteem, but there was no reason why he should have come to the attention of staff as someone who required special monitoring or support against self-harm.

92. I am satisfied that the man's transfer to Haverigg was at his request and, given that he had been there before, it is likely that he was content with the allocation. However, I am concerned that what appears to be an important medical examination did not take place due to his transfer occurring on the same day. That said, I am satisfied that this did not cause his death and am content that the Governor is to raise the subject of transfers with his Area Manager.

93. There is nothing to suggest that staff or prisoners believed the man to be vulnerable or knew anything about what he may have intended to do. The only event that appears to have been widely noticed is that the man had argued on the telephone with his girlfriend on the evening before he was found dead. However, despite the argument, the matter seemed to have been resolved by the end of the telephone call. It ended with the man saying that he loved his girlfriend and would be writing to her and would speak again on the phone.

94. I am satisfied that the decision taken not to attempt resuscitation was the correct one. To have done otherwise would have been indecent and inappropriate.

RECOMMENDATIONS

1 The Governor should ensure that the instructions contained in PSO 2710 are properly followed.

The Governor has accepted the recommendation

2 The Prison Service should examine whether it is feasible to provide nationally a computerised system compatible with that available in general medical practice and NHS.

The Prison service have accepted the recommendation

3 The Governor should ensure that sufficient time is available for all newly arrived prisoners at Haverigg to be given a proper clinical assessment.

The Governor has accepted the recommendation