INVESTIGATION

INTO THE DEATH OF A MAN AT HMP WAKEFIELD

IN SEPTEMBER 2004

Report by the Prisons and Probation Ombudsman for England and Wales

December 2005

The man was 24 years old at the time of his apparently self-inflicted death in HMP Wakefield in September 2004. This was his first time in custody, although he had previously received police cautions for minor offences. He had been in custody since July 2002, and had received a 12 year sentence for rape in February 2003.

The man had a history of risk of self-harm and had been subject to self-harm monitoring by the Prison Service, although at the time of his death he was not reviewed under these procedures. He was also receiving psychiatric input from the local mental health services including prescribed anti-psychotic medication.

He was apparently settling on C wing although he was reluctant to engage in the Sex Offender Treatment Programme. He acknowledged he had to do the course but did not feel ready to commit to it. He was seen by the SOTP facilitator on 28 September 2004 when he once more declined to participate. Later that evening, he requested a transfer from the wing as he stated he was being bullied. An immediate investigation was conducted and staff were satisfied that there was no bullying taking place. The man also indicated to staff that he was not at risk of self-harm.

An entry was made in the wing observation book regarding the events of that evening and requesting that additional checks be made on the man over the next few days. At 6.05am on 29 September 2004, the man was discovered with a ligature round his neck.

The man's death occurred at a time when the investigation of deaths in prison custody was subject to transitional arrangements agreed between my office and the Prison Service. Accordingly, I commissioned a Residential Manager at HMP Frankland, to investigate the circumstances of the death. The Residential Manager was assisted by a Principal Officer from HMP Manchester and an investigator from my office provided liaison and support. I am most grateful to all of them.

I am also obliged to the Prison Lead at the Northumberland Care Trust, for conducting a detailed clinical review of the man's healthcare.

I thank the former Governor at Wakefield, his appointed Liaison Officer and his colleagues for their assistance throughout this investigation.

I would like to offer my sincere condolences to the family and friends of the man who is the subject of this report following his tragic death. The man was a vulnerable young man and the very thorough investigation conducted on my behalf has generated a significant number of recommendations.

This version of my report, published on my website, has been amended to remove the name of the deceased and the names of staff and prisoners who were involved in my investigation.

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

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1 SUMMARY

1.1 This is a report on an investigation into the death of the man in September 2004 in HMP Wakefield.

1.2 The investigation team reviewed prison records and interviewed prisoners and staff. My Family Liaison Officer visited the man's home town and heard the concerns of members of his family. In all, there were 19 formal recorded interviews, as well as a number of statements. According to records, the man had previously self-harmed.

1.3 The man was arrested in July 2002 and charged with rape. He was convicted towards the end of 2002 and sentenced to 12 years imprisonment with a four year extended supervision period thereafter in February 2003. He was initially held at HMP Forest Bank on remand and transferred to HMP Manchester and HMP Altcourse, with a further transfer shortly after conviction to HMP Wakefield.

1.4 HMP Wakefield was aware initially that the man had been previously identified at risk of self-harm. He received psychiatric input and anti-psychotic medication which required a period of stabilisation, requiring him to be on self-harm monitoring and in the Healthcare Centre in November 2003 and briefly again in February 2004.

1.5 The man thereafter appeared to be stabilising on C-wing and Healthcare staff authorised advance medication for him, trusting him not to overdose on it.

1.6 However, following an interview by a Sex Offender Treatment Programme (SOTP) facilitator in his workshop on 28 September 2004, the man complained to his Wing SO on C-wing that he was being bullied by other prisoners to do SOTP.

1.7 This was investigated by landing staff and the 'bully' identified. However staff were satisfied that no bullying was taking place. The issue over SOTP was resolved and the man indicated he was not at risk of self-harm that evening.

1.8 An entry was made by the Landing Officer in the man's history sheet and on the C-wing observation book to keep an eye on him, but this did not generate additional checks on the man overnight by night staff.

1.9 At 06:05 hours the following morning, the man was discovered with a ligature round his neck and could not be resuscitated.

1.10 Paramedics were summoned and declared the absence of vital signs, which was confirmed one hour later by the Duty Doctor.

1.11 The man had rung his sister the previous night to tell her about his concern about being bullied. His voice during the telephone call did not sound unduly distressed and he seemed equally interested in events in his sister's life.

1.12 This investigation has found evidence of a certain vulnerability and psychiatric confusion on the part of the man, including auditory hallucinations and grooming by older prisoners.

1.13 This report identifies certain issues regarding

- bullying of the man,
- the response to the entry made about him in the C-wing observation book,
- a delay in entering his cell when he was initially discovered,
- the lack of experience on the part of the Night Orderly Officer,
- a lack of patrolling by night staff
- a lack of self-harm awareness training across the prison as a whole
- a lack of input from Personal Officers, resulting in sparse entries on history sheets.

1.14 The report also identifies problems in

- handling the incident,
- passing wrong information to National Operations Unit (NOU),
- delays in contacting the man's family,
- a Duty Governor not contributing to the death in custody incident file,
- no cell door log having been maintained at initial entry into the man's cell
- no critical incident debrief having been held within a reasonable time by management for First on Scene staff.

1.15 The report also identifies the need for HMP Wakefield

- to remind night staff about patrolling duties
- to maintain up-to-date details of prisoner's next of kin, and
- to offer bereavement counselling to prisoners whose relatives die.

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1.16 The report also identifies the common feature of hinged windows in cells being used as ligature points

2 INVESTIGATION

2.1 I appointed the Residential Governor at HMP Frankland to conduct the investigation on my behalf.

2.2. The investigator visited HMP Wakefield where he received a brief from the Governor's Liaison Officer, ahead of visiting the man's cell. He also met with members of the Prison Officers' Association (POA) local branch committee. My Family Liaison officer, visited the man's family in Greater Manchester.

2.3 I issued a notice to prisoners and staff inviting anyone who might have information relating to the man's death to make themselves known to the investigation team.

2.4 The investigation team interviewed prison staff and prisoners from neighbouring cells.

2.5 They examined the man's prison record and a series of prison documents listed in the appendices.

2.6 Wakefield West Primary Care Trust commissioned the Northumberland Care Trust to conduct a clinical review of the man's care whilst in prison custody.

2.7 A meeting was held with the Independent Monitoring Board for HMP Wakefield and a Notice of Investigation spelling out the objectives of the investigation was issued.

2.8 Formal interviews were recorded on tapes producing a verbatim record. Those being interviewed were allowed to be accompanied by a friend or colleague, or trade union representative, as appropriate.

3 THE MAN'S TIME IN PRISON

3.1 The man was convicted of the rape of a young girl in 2002. He was sentenced to 12 years imprisonment with a four year extended supervision period thereafter in February 2003. The man was initially held at HMP Forest Bank on remand and transferred to HMP Manchester and HMP Altcourse, with a further transfer shortly after conviction to HMP Wakefield on 21 February 2003.

3.2 Whilst on remand and awaiting sentence at HMP Forest Bank, HMP Manchester and HMP Altcourse, the man presented as anxious and emotional. He received psychiatric support and family support from his sister and brother-in-law. He obviously took time to assimilate to prison conditions and only started to mix with other prisoners several months into his period of remand. He presented to staff at that time as vulnerable and withdrawn, with some element of psychiatric confusion. When being transported to court, escorting agencies were warned about his mental condition and of his vulnerability and suicide/self-harm ideation. There was some information of him having tried to hang himself with his shoelaces on a Prisoner Escort Record (PER) form dated 21 August 2002.

3.3 The investigation team inspected the man's history sheets. At HMP Forest Bank in July 2002, he is reported as being on 15 minute self-harm watch in Healthcare and then on the wing in a withdrawn state "punishing himself for what he has done". He spent further time in the Healthcare Centre in August 2002. He was transferred to HMP Manchester on 16 August 2002. He is reported as talking to himself, being unstable mentally and prone to crying, but compliant with the regime. He was transferred to HMP Manchester's segregation unit on own protection on 5 September 2002, with evidence of requiring anti-psychotic medication. He was subsequently transferred in September 2002 to HMP Altcourse, gradually coming out of his shell and partaking in wing association. When sentenced on 7 February 2003, he was offered a Healthcare location at HMP Altcourse while coming to terms with his 12-year sentence, but declined this. He was then transferred to HMP Wakefield on 21 February 2003.

3.4 Wakefield identified initially that he had been previously on F2052SH monitoring in July and September 2002, with an initial assessment that he posed no risk of self-harm at HMP Wakefield.(F2052SH is a document opened by prison staff to ensure closer observation of a prisoner who has self-harmed or is thought to be at risk of self-harming.) He received warnings in mid 2003 about the state of his cell and initial poor time keeping in respect of his job. He was moved to the Healthcare Centre in November 2003, with the suggestion he was being bullied on C-wing, but he returned to the wing after a period of 11 days on F2052SH with a further move to the Healthcare Centre in February 2004 to stabilise medication problems. This was followed by a period of stability on C-wing in mid 2004 when he was said to have come to terms with the wing regime. The final entry on his history sheet at HMP Wakefield is as follows, "The man reported to the Senior Officer stating he wanted to move off the wing due to him being bullied. He would not state who was responsible. I spoke to him and although he

wouldn't grass I discovered the culprit to be another prisoner, a good friend of the man. The prisoner concerned approached me and stated the business may be about him. Apparently the man didn't want to do groupwork and this other prisoner had been trying to talk him into doing the groups to better himself. Now the matter is in the open I think things will quieten down as the other prisoner shows no indication of being a bully." This entry was made by the Landing Officer, on 28 September 2004. The man who is the subject of this report was discovered with a ligature around his neck the following morning. Also on his history sheet is a notice of an interview by police in July 2003 relating to the potential for further charges which were apparently not proceeded with.

3.5 During his time at HMP Wakefield, the man was also informed of the death of his grandmother (in August 2003).

3.6 His security file contained few entries although there was an entry in August 2002 where he was found in his cell with red marks round his neck punching himself in the face. A further entry suggests there may be further charges in relation to alleged offences against a family member; yet another entry suggested he might be the victim of some bullying in November 2003.

3.7 Examination of his visiting orders revealed that he was most regularly visited by his sister and her partner. He was last recorded as having received a visit from his sister on 23 September 2004.

3.8 An Offender Analysis (OASys) of the man was examined. It said that he had a history of gambling, poor financial management and recklessness in the perpetration of the index offence. OASys stated that he had experimented with solvents, taking anti-depressants and Benzodiazepine. OASys referred to periods of depression, to his difficulty sometimes in sleeping and coping and to his medication for psychosis. OASys noted a recent history of self-harm and that he had taken overdoses five or six times previously, having been on F2052SH self-harm monitoring from 20 July 2002 to 4 September 2002. He was described on the form as socially inadequate and isolated, suffering from chronic psoriasis on elbows, knees and scalp, on medication for psychotic problems, showing signs of vulnerability and a risk to children. At the time the OASys documentation was completed in mid 2004, there were no concerns about self-harm. It was identified that he should attend relevant treatment programmes to stabilise his mental state. At the time he acknowledged some recklessness in his offence and said it was a result of being depressed and stressed, but he denied a risk of re-offending in the future. The OASys recommended the need for him to attend SOTP.

3.9 At successive Sentence Planning Boards it was recorded that he needed to be assessed for Enhanced Thinking Skills (ETS) and SOTP with risk factors of use of violence and threats, poor coping strategies, relationship skills deficit, poor emotional control and cognitive deficits. By mid 2004, he had completed ETS but the SOTP was still outstanding. There was some suggestion by mid 2004 of previous offences, with reference to his reluctance to discuss the nature of those offences, or indeed the nature of his index offence, at any SOTP course.

3.10 Educational assessment of the man’s indicated the need to pursue some

qualifications in basic and key skills and to improve his confidence in doing groupwork.

3.11 Inspection of psychology unit record notes reveals an initial discussion when the man arrived at HMP Wakefield about how he would benefit from programmes, some identification of psychiatric problems, concern about talking about his offences in front of others, and completion of ETS to develop confidence in discussing issues in front of others. The man admitted being a regular shoplifter and having sexual fantasies about children. Records also indicate that by mid 2004 he was still apprehensive about doing SOTP. A further approach was made by the officer who was the SOTP facilitator to the man on 28 September 2004 in Workshop No. 3 in the afternoon. His psychology file is annotated: "Quick check with the man to see if he was interested in attending SOTP. At first he said he was interested but only if he could come off whenever he wanted and that there would be no one else on from his wing. I told him these issues could be looked at, he then said 'No I don't want to do it yet I'm settled on the wing'. I asked him if he wanted me to review him in six months, he said 'Yes that would be better for me'. Need to check motivation in six months, seems to want to do SOTP when he feels the time is right".

3.12 The investigators interviewed the Programmes Co-ordinator (an Acting Senior Officer), about the man's completion of ETS. The man started the group being quite shy and reserved but subsequently came out of his shell. He showed increased confidence and became a really good group member. He completed an Other People's Views survey at the end of the course.

3.13 A Registered Mental Nurse (RMN) was interviewed as he had had some input into assessing/counselling the man at HMP Wakefield. He said the man had complained of mood swings, depressive type symptoms, and auditory hallucinations, accompanied by problems taking his medication. He was prescribed anti-psychotic medication which had the side effect of sleep disturbance. The RMN described the voices the man was hearing as derogatory towards him.

3.14 An examination of the man's Inmate Medical Record (IMR) revealed records from his time in the community dating back to 1998 showing he then had a gambling problem and low self-esteem along with some alcohol problems and inability to cope. The records also show a history of deliberate overdose, thoughts of wrist cutting and evidence of a dysfunctional upbringing and family dynamics not conducive to good emotional development. The IMR records from HMP Altcourse reveal him to have been prescribed Amitriptyline (anti-depressant medication) and he had a low mood during court appearances whilst on remand. The man's prescription history states that his prescription was changed to Olanzapine (anti-psychotic medication) whilst at HMP Wakefield which required some stabilisation, but latterly there was no problem with him being prescribed this type of medication in advance.

3.15 The man is recorded on his IMR as appearing depressed and low in mood during his court appearances. He was prescribed anti-depressant medication, requiring periods of stabilisation in the Healthcare Centre at HMP Altcourse with ongoing psychiatric assessment. He presented as

incoherent and childlike, requiring regular psychiatric input. The man transferred to HMP Wakefield upon conviction. He had some problems with his medication, experiencing some significant mood swings and maladjusted sleep patterns and the reappearance of auditory hallucinations. He was seen at risk of self-harm in November 2003 and taken into the Healthcare for monitoring and then returned to C-wing, occasionally lapsing thereafter into incoherence and thought disorder. In mid 2004 he was on "observation" in the Healthcare Centre, hearing voices and having maladjusted sleep patterns. He had ongoing anxiety about his psoriasis and was discovered with a ligature around his neck on 29 September 2004. Shortly before that date he was assessed as suitable to have seven days medication in possession.

3.16 Past self-harm (F2052SH) monitoring forms were examined. They state that the man was periodically confused and disorientated with low mood, behaving bizarrely, and that he required psychiatric input, as he presented as vulnerable and subject to bullying. He needed to come to terms with his sentence and prison life. He attempted to hang himself in July 2002 and cut his wrists. He was described as having a generally poor coping strategy, characterised by rapid mood swings.

4 INFORMATION FROM OTHER PRISONERS

4.1 Seven prisoners were interviewed formally for the purposes of the investigation and a number of other prisoners were interviewed informally.

4.2 One prisoner from D-wing indicated the man had told him a few days before his death that he was being abused by prisoners on C-wing and potentially groomed by older prisoners. The prisoner from D-wing also confirmed the man's vulnerability generally, his immaturity and lack of prison coping skills. This prisoner also surmised the man may have been in debt in view of his weakness for confectionery and tobacco and may have used a favourable response to homosexual advances to repay the debt.

4.3 Another prisoner corroborated the D-wing prisoner's evidence and also had his own view about some prisoners being bullied to do accredited programmes by psychologists at HMP Wakefield.

4.4 Two prisoners from C-wing wrote to the Ombudsman on 29 September 2004 volunteering information about the man, and they were also interviewed for the purposes of this investigation. These prisoners reported their knowledge of the man being approached in the No. 3 Workshop on the afternoon of 28 September 2004 with a view to being persuaded to do SOTP, and a discussion amongst other prisoners around whether or not he needed to do SOTP. These prisoners also reported their knowledge of the man being bullied previously by other prisoners. One of the prisoners who wrote to the Ombudsman from C-wing reported noticing problems the man was having with his medication and his concern that he would be reduced in Incentives and Earned Privileges (IEP) status if he did not agree to do SOTP.

4.5 One of the C-wing Listeners also wrote to the Ombudsman and was interviewed. He indicated that he had spoken to the man informally on a number of occasions and had noticed periods when he became withdrawn. However, he observed nothing of overriding concern that required passing on to staff on 28 September 2004.

4.6 The prisoner opposite the man's cell who was accused of bullying him to do SOTP was interviewed. This prisoner reported noticing mood swings in the man, periods where he required Healthcare intervention to stabilise his medication, feelings of depression and behaving in an immature fashion. This prisoner saw the man being interviewed in the workshop on the afternoon of 28 September 2004 by an SOTP facilitator and discussed with the man afterwards the need to do SOTP to achieve parole. This prisoner became aware the man had been upset by this and that he had gone to see the SO subsequently and asked for a wing move. The prisoner volunteered to a landing officer to speak to the man in his cell, to set the record straight about the man's concern over being bullied by other prisoners to do SOTP. Afterwards the man lay on his bed watching TV.

4.7 The prisoner in the cell next to the man's was also interviewed. He indicated that he kept an eye on the man. He was aware the man had asked for a wing transfer and asked him why. He knew the man was upset but not enough to cause concern. He reported that the man was well liked by other prisoners and there were a lot of people looking out for him on the wing. This prisoner noticed nothing unusual during the night following which the

man was discovered with a ligature round his neck.

4.8 Various other prisoners were interviewed informally. They stated that the man seemed fine the night before, but had a history of requiring stabilisation in the Healthcare Centre and being subject to bullying. They described him as nervous, lonely, depressed, reliant on visits from his sister and subject to mood swings. They spoke of him as vulnerable and not used to prison life, having problems with sleep patterns and hearing voices. They added that he seemed withdrawn and worried about doing SOTP, unstable and guilt ridden and reticent about his offences.

4.9 One prisoner who did not wish to be interviewed formally indicated that the man might have had an altercation on the morning of 28 September 2004 in the workshop with an Iranian prisoner who made unwelcome comments about his psoriasis. However, the man had not approached staff over this.

5 DISCOVERY OF THE DEATH

5.1 A brief chronology of events on 28 and 29 September 2004 is shown at Appendix A20 [not published in this version on the website].

5..2 Another prisoner has reported to the investigation team that, around 11:30 on 28 September, the man was involved in an altercation with an Iranian prisoner in Workshop No. 3 who commented adversely on his psoriasis. He returned to C-wing for his lunch and then went back to the workshop in the afternoon. Around 14:00, he was called on by the SOTP facilitator, to discuss the possibility of him commencing SOTP; he declined. At around 15:00, still in the workshop, he was involved in an animated discussion about the merits of doing SOTP with other prisoners. The man then returned to C-wing and around 17:00 was seen by the laundry orderly 'lost in his world'. At the commencement of evening duty, just before 18:00, the man approached the Senior Officer on C-wing and asked for a wing move. He then rang his sister to tell her that he had asked for a wing move because he was being bullied to do SOTP. At around 18:30, he was seen by a landing officer, along with the prisoner in the cell opposite his about why he had asked for a wing move and complained that he was being bullied. The landing officer was satisfied that the prisoner, whom the man appeared to be accusing of bullying him, was not in fact a bully. Just before 19:00, the landing officer made an entry in the C-wing observation book that he had dealt with the issue but that staff should keep an eye on the man for a couple of days.

5.3 At around 20:30, the night patrol officer took over and received a handover from the landing officer including reference to the entry in the observation book. Around the same time the night officer, completed a roll check and saw the man for the last time alive in his cell, saying that he appeared to be fine. All cells on the residential wings at Wakefield are single occupancy. At 23:35 on 28 September, and 04:51 on 29 September, the night officer pegged adjacent to the man's cell but did not open the flap on the cell door to look in. Pegging points provide a timed record of the parts of the prison visited by night patrol staff during the night. At around 06:00 on 29 September, the night officer commenced a final roll check prior to handing over to day staff but at 6:05 discovered the man in his cell with a ligature round his neck. The night officer ran to the residential centre to alert other staff. A radio message was passed by the Assistant Night Orderly Officer at 06:06 to the Emergency Control Room (ECR) asking the Night Orderly Officer to report urgently to C-wing. Around 06:10 a dog handler was asked to escort a Healthcare Officer to C-wing and at 06:13 an ambulance was summoned. At 06:15, the Night Orderly Officer arrived at the man's cell and the Night officer and two other officers entered the cell using the Assistant Night Orderly Officer keys. At 06:17, a Healthcare Officer arrived at the scene, and at 06:25 paramedics arrived. At 06:29, paramedics confirmed the absence of vital signs, and at 06:40 the man's cell was sealed. At 06:42, the police were informed of his death and the Press Office and NOU shortly thereafter. At 06:50, the ambulance with paramedics left the prison. At 06:59, the Coroner's office was informed of the death, and at 07:00 the governing Governor was informed. At 07:30, the Duty Doctor attended the prison and pronounced the man dead. At 07:55 his cell was sealed and at 09:38 scenes of crime officers arrived and entered the cell. The Coroner's officer arrived shortly thereafter. At 10:44 the undertakers arrived at the cell

and at 10:47 the man's body was removed to the mortuary, with his cell being sealed thereafter.

5.4 The SOTP facilitator who had spoken to the man on 28 September was interviewed. He stated that the man had indicated he realised he had to do SOTP but did not want to do it at this stage. The facilitator admitted it was apparent to other prisoners that the man was being asked to do SOTP as he was called out of the workshop to be spoken to. This was the practice that was currently being followed. The facilitator confirmed that no discussion took place about the man being downgraded on the IEP scheme if he refused to do SOTP. He confirmed that another prisoner had been accused of bullying the man to do SOTP. He had himself been identified for SOTP but, since the man's death, had dropped out of the SOTP course.

5.5 A tape of a phone call the man made to his sister on the evening of 28 September was listened to by the investigation team. In the conversation, the man was complaining about being bullied by another prisoner to do SOTP and asking for a wing move, but did not come across as contemplating self-harm and exchanged pleasantries with his sister. Although the man did not name the other prisoner in his phone call with his sister it is clear from his description and as a result of him volunteering to staff that he had been discussing doing SOTP with the man who he is.

5.6 The SO on C-wing on the evening of 28 September was interviewed. He stated that the man had approached him about a wing move but that he did not seem distressed. The issue with another prisoner was resolved by a landing officer speaking to both men. The man had told the SO that he had an issue with a prisoner, not that he was being bullied, and he also would not name the other prisoner with whom he had an issue. The SO saw an entry made subsequently in the observation book by the landing officer who spoke to both men. The SO had done no particular handover of the "need to keep an eye on [the man]" as entered in the observation book to the oncoming night staff. He indicated to the investigators that it was the responsibility of the night staff to read the observation book. The SO had been satisfied that the differences between the man and the other prisoner had been resolved and that there were no ongoing bullying issues.

5.7 The landing officer was also interviewed by the investigation team. He confirmed he had spoken to both men and said the issue appeared to have been resolved. The man stated he was pleased the issue had been aired. The landing officer saw the man again at about 20.00 hours and he stated he was fine. The landing officer was not the man's Personal Officer but knew him well and was an experienced landing officer. He confirmed that he had made an entry in the observation book suggesting staff should keep an eye on the man for the next few days. He stated that it would be his expectation that the night staff would keep an eye on him by checking him through the night.

5.8 The observation book entry made by the landing officer states, "28.9.04 [the man] approached [the SO] stating he wanted off the wing as he was being bullied. Investigation revealed the bully to be a friend of his [the other prisoner]. [The other prisoner] states he has been encouraging [the man] to do groupwork. [The man] confirmed this and classed it as bullying. [The

other prisoner] will leave him alone. Would staff keep an eye on [the man] during the next few days."

5.9 The night handover sheet from day to night staff on C-wing was examined. It indicated a couple of prisoners requiring monitoring because they were on self-harm monitoring, along with a couple of first night receptions, six prisoners with special needs and 33 Category A prisoners (the highest security category).

5.10 The day to night handover officer, was also interviewed by the investigation team. He confirmed he had passed on the above statistics to the night officer on C-wing on 28/29 September. He advised the night officer to read the observation book. The handover officer said, in view of the entry in the observation book, he would have expected the night officer to check on the man a couple of times overnight. The handover officer confirmed that he did not wait for the night officer to complete a roll check to confirm the roll before he left the wing. He confirmed he personally would have checked the man when he did the pegging overnight. The peg clock was adjacent to the man's cell and he was a well-known prisoner on C-wing amongst both prisoners and staff. The handover officer said that the Assistant Night Orderly Officer and Night Orderly Officer should also have noted the entry in the observation book and discussed with the night officer how they would keep an eye on the man.

5.11 HMP Wakefield's Night Officer instructions indicate that there is a pegging clock at the far end of the landing on Level 1 on C-wing to be pegged at 23:50 and 04:50. The instructions add that the handover from day to night should include the observation book and that in the event of discovery of self-harm the Control Room should be phoned or radioed. The record of pegs actually completed by the night officer confirms that pegs were made adjacent to the man's cell at 23:55 on 28 September and 04:51 on 29 September.

6 STAFF RESPONSE

6.1 The night officer on C-wing on 28/29 September, was interviewed. He confirmed he knew the man in advance. On 28 September, he had observed the man through the flap of his cell at around 21:00. He was either listening to his radio or watching his TV and said that he was fine. The night officer confirmed he had looked at the observation book as part of the handover, but did not recognise it as requiring further observations on the man other than those carried out at roll checks. He confirmed he had pegged adjacent to the man's cell but not looked into the cell during the night. He had not heard or seen anything whilst he did that, and continued with other pegs, and the necessary security Cat A and F2052SH checks. He completed a security check of every cell door, including the man's, at around 02:00 on 29 September. The night officer stated he had received several visits during that night from the Night Orderly Officer and she was aware of the issue raised about the man in the observation book. When the night officer commenced his roll check at 06.05 in the morning, he discovered the man had a ligature around his neck attached to the window. He ran as fast as he could to the centre to raise the alarm with the Assistant Night Orderly Officer, but did not use his radio to raise the alarm from the cell door. Three other staff then returned to the man's cell door and used the Assistant Night Orderly Officer's keys to enter as soon as the Night Orderly Officer arrived. The ligature was severed; it was made out of a green torn bed sheet. There were no vital signs and the man's face was discoloured. The body was cold and stiff and he was laid on the bed. The healthcare officer then arrived about 06:20 and soon after that the paramedics. The paramedics declared the absence of vital signs. No resuscitation or defibrillation was attempted and the cell was then padlocked and the necessary paperwork completed. The night officer confirmed that nothing was in the cell such as a note to the man's family or anyone else.

6.2 Evidence from other staff responding was examined. Their evidence was of a slight delay between information being passed about the discovery of the man and the cell being entered. They confirmed that there were no vital signs and the body was discoloured, stiff and cold.

6.3 The Night Orderly Officer was also interviewed and stated that she had only been recently promoted to Senior Officer and had just completed a week's induction for the position. She said she had read the observation book on C-wing and was aware of those prisoners on F2052SH monitoring. She stated she had previously been a C-wing Officer. She was aware that the man and the prisoner who had been accused in the observation book of potentially bullying him were friends. She took no particular note of any adverse effect on the man, believing the landing officer to have resolved it. The Night Orderly Officer was informed of the night officer's discovery of the man when she was in the grounds of the prison. She made her way to C-wing and then to the man's cell. Staff entered and she remained outside. She ensured an ambulance had been called confirming absence of vital signs at 06.29 hours. She acknowledged there might have been some delay in entering the man's cell after discovery, as the Assistant Night Orderly Officer waited at the centre before proceeding down to the man's cell with her, and it was the Assistant Night Orderly Officer's keys that were used to enter his cell. The staff had not used their sealed packs to enter the cell prior to that. No

resuscitation was attempted as the man was stiff and cold. The hospital officer arrived shortly thereafter accompanied by a dog handler from the hospital. Paramedics arrived shortly after that and pronounced the absence of vital signs. The Duty Governor and then the Duty Doctor arrived.

6.4 Governor's Order 306/04 was examined. It requires staff to raise alarms in emergencies preferably via radio and for staff to enter cells in emergencies immediately when two of them are present.

6.5 Information from the control room senior officer was examined. This stated that the initial reporting of the discovery of the man was at 06:06 on 29 September and an ambulance was requested at 06:13.

6.6 The duty doctor was interviewed. The doctor stated he had examined the man and found him stiff. There were no vital signs, no heart sounds or respiration and no reflexes. He declared life extinct at 07:30.

6.7 The duty governor was also interviewed by the investigation team. She confirmed she had received a call at around 06:05 on 29 September telling her the man had been found hanging. She immediately came to the establishment and arrived about 25 minutes later. She proceeded to C-wing to the man's cell, being informed that paramedics had declared the absence of vital signs when she arrived. She arranged for a door log to be commenced and spoke to various staff to ensure they were coping. A governor had collated various paperwork relating to the incident and made some initial contact with NOU. She received a call from NOU to clarify things subsequently. She stated she had not prepared a written report at the time. She confirmed no Cardio-pulmonary resuscitation (CPR) had been attempted on the man, although information that CPR had been attempted seemed to have been passed mistakenly to NOU. It was noted from the interview with the duty governor that a critical incident debrief had still not taken place but was planned. She confirmed that, as HMP Wakefield was a treatment centre focusing on SOTP, it would not be unusual for prisoners to be called out to discuss doing SOTP from workshops as occurred with the man on 28 September. She confirmed that the observation book entry on C-wing to keep an eye on the man, in her interpretation, would have entailed the night officer keeping an eye on him periodically by opening his cell flap to ensure that he was well. The duty governor also confirmed no suicide note was found.

6.8 The report to Home Office Ministers arising from the incident was also examined. It reported mistakenly that CPR had been applied.

6.9 The incident log report completed at the time was reviewed. It confirmed the initial report at 06:06, the arrival of healthcare staff at the man's cell over ten minutes later, the arrival of ambulance staff at the man's cell over five minutes after that, declaration of absence of vital signs at 06:29 and subsequent contact with the Coroner's office,

6.10 The cell door log was also examined. It confirmed that the doctor pronounced death at 07:30 and that the man's body was removed from the cell at 10:47. The log showed that the cell was finally sealed at 10:50 and listed a number of items removed by the police.

7 NOTIFYING THE MAN'S FAMILY

7.1 Two of my colleagues visited the man's mother and sister on 2 November 2004. The family raised concerns about him being bullied over doing SOTP by another prisoner; why he was not checked overnight on 28/29 September, why he was not on self-harm monitoring, whether he left a suicide note, why the family was not informed directly by prison staff of his death by coming to their home, why police were sent; why there was a delay in the prison returning their call once they had rung and why the prison did not offer to help with the funeral costs until prompted to do so by the Coroner's office.

7.2 The duty governor was asked about these concerns from the family as she had been appointed as liaison between the prison and the family. She reported that the prison's policy was always to ask the local police to contact next of kin if a prisoner died to avoid information being given by telephone and without verification of identity. Face-to-face contact with family members was regarded as an issue for the police rather than prison staff. Efforts had been made by Greater Manchester police to contact the man's next of kin at the last known address without success. A visit had been made by the police to a cousin's address and the man's mother had subsequently rung the prison. In view of the prison's policy, when the prison first received the phone call from the man's mother, the governor who took the call did not divulge the details of his death, preferring instead to verify that the police had made face-to-face contact first. He promised that the prison would ring back within an hour. The reason for the prison not ringing back within that hour was that the police had still not made contact with the man's family. Information was passed on when his mother rang back a second time. Because the police had still not made contact with the family by 14:30 on 29 September, the duty governor took it on herself to inform the man’s mother of her son’s death, having first established that she had someone with her to comfort her. The information was passed and the family asked for no further contact with the prison.

7.3 The following day, concerns about funeral costs were raised by the family with the Coroner. Discussions about funeral costs had not taken place the previous day through respect for the family's grief. When it was ascertained from the Coroner that the family were asking for more information about assistance with funeral costs, the duty governor volunteered to the man’s mother that funds were available through the prison up to the sum of £2,000.

7.4 The duty governor explained to the investigation team that it had been easy to identify the prisoner that the man thought was bullying him, as he had volunteered his name to the landing officer. The landing officer was an experienced landing officer and was satisfied that, as the two men were friends, and the other prisoner was open about telling him that he had been discussing SOTP with the man, he was not bullying him. He entered this on the man's history sheet and in the C-wing observation book.

7.5 The landing officer was not concerned that the man might be suicidal and there was no suggestion of any self-harm in the discussions with him on the evening of 28 September. He was merely expressing concerns over doing SOTP and about being bullied by other prisoners over it and initially

broached a wing move. The staff did not feel it necessary to open self-harm monitoring procedures on him in view of the way he presented. They were all aware, however, of his previous self-harm background.

7.6 Finally, the duty governor explained that the prison had not offered any follow-up care to the man's family because, in phone calls around the time of his death, the family appeared to be declining further contact.

8 POST-INCIDENT RESPONSE

8.1 HMP Wakefield has contingency plans relating to deaths in custody and these appear to have been followed. The police were informed; the press office was informed; the prison doctor was called along with paramedics in advance; the Coroner had been informed; the NOU had been informed (and they in turn informed Prison Service senior management); the IMB had been informed. After the man's body had been removed to the mortuary by undertakers, his cell was sealed pending the Coroner's investigation and the Coroner's release of the "crime scene" and his effects. Staff involved in discovering the man were offered counselling and care team support. His friends on the wing were informed in a sympathetic way. In terms of notifying the family the prison's Police Liaison Officer from West Yorkshire Police contacted Greater Manchester Police by fax to ask them to inform the next of kin in person. The fax was dated 09:49 on 29 September. The Governor's journal entry for 28 and 29 September is attached to this report along with the report completed by the Night Orderly Officer [not published in this version on the website]. A number of Security Information Reports were generated from other prisoners as a result of the man's death. They identified other prisoners who might need to be interviewed by the police and the Ombudsman as part of their investigations. These prisoners were duly interviewed.

9 HMP WAKEFIELD'S POLICIES AND PROCEDURES INCLUDING ITS SUICIDE PREVENTION STRATEGY

9.1 HMP Wakefield was designated high security in 1966. It is a lifer main centre with a focus on serious sex offenders. Its regime includes full-time, part-time and evening classes in education, workshops, training courses, a works department, kitchen, and farms and gardens. There are also offending behaviour courses, e.g. SOTP, ETS and Learning Difficulties groups. Drug Rehabilitation Programmes and Alcohol education courses are available and an active Listener scheme is in operation in the prison under the auspices of the Samaritans.

9.2 The main buildings date from 1845; the prison is Victorian in style and has a radial system of wings with a separate segregation unit and Healthcare Centre. The prison has been undergoing a programme of refurbishment in residential areas. It houses mostly sex offenders and some elderly and infirm prisoners. It specialises in high quality intensive offending behaviour programmes.

9.3 An inspection carried out in October 2003 by Her Majesty's Chief Inspector of Prisons (HMCIP) found a proactive approach towards suicide and self-harm on the one hand, with a certain disengagement and disrespect towards prisoners by staff in residential areas on the other hand. HMCIP describes good practice by Suicide Prevention and Anti-Bullying Officers doing follow-up interviews on prisoners previously regarded as at risk of self-harm, and the Head of Residence sampling F2052SH forms. The report also highlights the multidisciplinary approach to F2052SH reviews, HMP Wakefield's active Listener Scheme and Anti-Bullying Committee. It criticises the Personal Officer Scheme as being ineffective and states that history sheet entries were often sparse. A check of the man's HMP Wakefield history sheet reveals there were only 21 entries in his 20 months at the prison plus five management checks.

9.4 There was a Standards Audit at HMP Wakefield in June 2004. Most baselines audited in relation to suicide and self-harm prevention were found to be fully compliant, with only minor action identified for those that were not. A survey was conducted on prisoners by the auditors; the majority agreed it was easy to see a Listener at HMP Wakefield. Discussions by auditors with prisoners also revealed that suicide and self-harm issues were not always dealt with diplomatically. Some prisoners felt that they were unable to receive help from staff in this area as they had previously approached staff and received no support. Other prisoners reported that, if someone was at risk of suicide or self-harm, then there were sufficient facilities available to offer support, e.g. Healthcare and the Samaritans. The audit of the safety critical baseline produced the comment that significant attention was paid to required measures for suicide and self-harm prevention. The audit report also stated that F2052SHs were opened whenever risk was identified and that support plans were good. It reported that the Listener scheme was active and Listeners had meetings with the Samaritans every other week. Officers confided in Listeners if they were concerned about a prisoner. There were mixed responses as to whether prisoners would approach a Listener as some prisoners were worried about confidentiality. Prisoners commented to auditors that there was little bereavement counselling for

those prisoners who had lost a relative and they felt this had caused frustration and anger. There was some criticism by the man's family about the way he had been informed about the death of his grandmother in 2003.

9.5 The recommendations arising from a recent Ombudsman's investigation at Wakefield into the death of a high profile prisoner were examined by the investigation team. These recommendations included:

- Reviewing the effectiveness of the Personal Officer scheme.
- Eliminating inconsistencies within the Suicide Prevention Policy document and instructions to staff on residential units.
- Ensuring all staff were aware of the circumstances in which they may enter a cell in a medical emergency.
- Reviewing instructions relating to when resuscitation need not be begun.
- Reviewing the establishment's incident paperwork to ensure all staff were aware of it, including a review of the incident log paperwork in the control room.
- Ensuring that prisoners were reminded during induction and via notices that it was their responsibility to ensure that their next of kin details were up to date.

These findings were relevant to the man's death in that he had not had much contact with his Personal Officer and there had been few entries on his history sheet by the Personal Officer. Staff still seemed uncertain about certain aspects of handling a death in custody, i.e. when they should enter a cell and the completion of the incident file after the incident. There was no report from the duty governor and the main information gleaned from the duty governor was gained as a result of interviewing her.

9.6 HMP Wakefield's Suicide Prevention Policy and Strategy document dated May 2004 was examined by the investigation team. The document was compliant with the Prison Service Order (PSO) on suicide prevention.

9.7 The minutes of the last three meetings of the Suicide Prevention Team were examined. At the meeting on 26 May 2004, it was highlighted that C-wing had ten Listeners, there were detailing problems for Suicide Prevention and Anti-Bullying officers, and only one-third of staff were appropriately trained in suicide awareness. At the meeting of the Suicide Prevention Team held on 28 July 2004, the peer support system for prisoners undertaking programmes was discussed, as it was again at the meeting on 29 September 2004.

9.8 Records of staff training, relating to prisoners at risk of self-harm were examined. They revealed that 144 staff had received updated Suicide Awareness or Prisoners at Risk of Self-harm training within the last 18 months. The night officer who dealt with the man on 28/29 September had received prisoners at risk of self-harm training last on 17 October 2003. The wing SO, who the man approached about being bullied on the evening of 28 September 2004, had received Suicide Awareness training on 29 February 2000 but no Prisoners at Risk of Self-harm training. The landing officer, who interviewed the man with the other prisoner, had had Suicide Awareness on 25 February 2000 and 'Prisoners at Risk of Self-harm' training on 13 September 2002.

9.9 The Suicide Prevention and Anti-Bullying Co-ordinator, was interviewed by the investigation team. He indicated that on discovering the man had died he had reviewed F2052SH monitoring forms and had found them all to be compliant with policy. He volunteered that in view of the entry on 28 September 2004 in the C-wing observation book about keeping an eye on the man, he would have expected night staff to keep a check on him by opening his observation flap and having a look in his cell. He reported no Suicide Prevention and Anti-Bullying officers were detailed to evening duty. He said, if the man had complained about being bullied during the day, he would have designated two Suicide Prevention and Anti-Bullying officers to investigate. This could not occur on an evening duty as no Suicide Prevention and Anti-Bullying officers were detailed. C-wing had four Suicide Prevention and Anti-Bullying officers during a main shift. The co-ordinator stated that an F2052SH monitoring form would be raised along with monitoring procedures if any staff had concerns as to self-harm. All staff were aware of this. The co-ordinator commented in relation to the entry about the in the C-wing observation book that it appeared that the staff were satisfied that no self-harm ideation existed. Regarding the issue of the man being interviewed in Workshop No. 3 about his willingness to do SOTP, the co-ordinator stated in hindsight there would be probably better places to speak to prisoners about doing programmes, e.g. the wing, which would offer greater confidentiality. With reference to the delay in entering the cell after the body was discovered, he said that for preservation of life there should be no delay provided that sufficient staff were present. He commented on HMP Wakefield's integrated regime, suggesting that some sex offenders may be vulnerable to bullying.

10 CONCLUSIONS

The issues arising from this investigation may be summarised as follows:

- The circumstances and events surrounding the man's death were that he hanged himself from his cell window with a ligature made out of one of his bed sheets, some time after the night officer's initial roll check on C-wing at HMP Wakefield on Tuesday 28 September 2004. He was discovered by the night officer at his final roll check on Wednesday 29 September 2004 at 06:05, and there was up to a ten-minute delay in entering the cell thereafter. Vital signs were completely absent. Resuscitation was not possible nor was it attempted. The man was seen by paramedics who declared the absence of vital signs at 06:29. Death was declared by the duty doctor one hour later. The investigation has found no evidence of a suicide note being left.

- The man had been seen in Workshop No. 3 at HMP Wakefield on the afternoon of 28 September by an SOTP facilitator to discuss SOTP, but had said he was not interested in SOTP at this stage of his sentence. Other prisoners tried to persuade him to do SOTP and at teatime he complained to the C-wing SO that he had had an “issue” with another prisoner over this and requested a wing move. The SO arranged for a C-wing landing officer, to discuss it with him. Another prisoner, a friend of the man's, volunteered to the landing officer that he was the prisoner the man had the “issue” with.

- After he had seen the C-wing SO, but before being interviewed by the landing officer, the man rang his sister to tell her of the “issue”. He was obviously concerned but, to the investigator, he did not sound unduly distressed during the phone call, showing equal interest in his sister's life. His sister did not raise any concerns about any thoughts of self-harm by the man as a result of this phone call.

- The landing officer believed that his interview with the man (with the other prisoner also present), had resolved the issue. He recorded on the man's history sheet that he did not believe any bullying was taking place. He did not raise any self-harm monitoring but made an entry in the C-wing observation book of the need for staff to “keep an eye” on the man for the next few days. This entry was handed over by the C-wing late-duty officer to the C-wing night officer and also read by night manager(s). No additional checks on the man were made overnight. The night officer would have checked the man if he had been on any form of self-harm monitoring. He had three others who were being monitored, along with two new receptions and 33 security Category A prisoners that night.

- The Night Orderly Officer was newly promoted to SO and had only just completed her Night Orderly Officer induction. She relied on other more experienced night staff to decide on the level of monitoring of the man. Despite having read the C-wing observation book entry about him, she did not request any additional monitoring herself.

- Subsequent to the man being declared dead, at about 9:49 on 29 September the Police Liaison Officer at HMP Wakefield faxed Greater Manchester Police to ask them to contact his next of kin in person to inform them of the death. By 14:30, no contact had been made but his mother had become aware the police were trying to contact. She rang HMP Wakefield. Because the prison has a policy of requiring the police to make initial face-to-face contact with next of kin, no information was passed on, but a promise of a return phone call within the hour was made. No police contact occurred within that hour and the prison did not ring his mother back. His mother therefore rang the prison again. The duty governor then passed on the news to her over the phone and rang back later that day to discuss further details.

- Some time during 29 September, HMP Wakefield management rang Prison Service NOU to inform them of the man's death. Basic details were conveyed and further passed on by NOU to senior Prison Service management and to Ministers. This includes incorrect information that CPR had been attempted.

- The duty governor was telephoned by the man's mother again on 30 September and asked about funeral costs. She had not raised this the previous day out of respect for the mother's grief, but now informed the mother the prison would contribute £2,000 and that up to £600 was available from the Department for Works and Pensions. The family stated that they required no further contact with the prison and merely asked for his audio tapes to be posted to them and his other effects to be posted on once released by the Coroner.

- An incident file relating to the man's death was compiled by the prison but this included no specific contribution from the duty governor.

- First on Scene staff were counselled by management and offered care team support. However, up to 9 November 2004 when the investigation team last visited, no Critical Incident Debriefing for first on scene and other involved staff had been arranged.

- The man had been very distressed and disorientated whilst on remand. He made attempts to hang himself with shoelaces and cut his wrists with his jacket zip. He had also been maintained continuously on anti-psychotic medication whilst in prison. When he had had auditory hallucinations and adverse side effects from his medication, he had been stabilised by being placed on a Self Harm at risk form (F20525H) and/or by being admitted for a period to the Healthcare Centre. Recently, despite his vulnerable, immature presentation and potential for grooming and bullying, he seemed to be settling down and becoming accustomed to the regime at Wakefield. It was decided to allow him advance supplies of his medication rather than daily issues.

- Prior to custody, the man had minor previous convictions for shoplifting and possession of cannabis which attracted 'cautions'. He reportedly had substance misuse, alcohol and gambling problems and regular psychiatric input during his adolescent years.

- Up to 28 September 2004, staff at Wakefield were well aware of the man's background, but believed he was stabilising and becoming accustomed to prison life. His last input from psychiatric services was in June 2004.

- Suicide Prevention and Anti-Bullying Officers are deployed at HMP Wakefield to interview prisoners and investigate claims of bullying but they are not on duty in the evening.

- The level of training in identifying self-harm at Wakefield is a matter which HMCIP had previously identified as requiring attention. Inspection of history sheet entries for the man revealed on average only one per month, excluding management checks, and the management checks to have been infrequent.

- A recent Wakefield death in custody investigation report highlighted problems with contact of next of kin and the need for prisoners to be reminded that they should keep their next of kin details with the prison up to date. The details held by the prison of the man's next of kin were not up to date.

- The Standards Audit of Wakefield in June 2004 highlighted the need for better bereavement counselling of prisoners. The man was informed of the death of his grandmother in 2003 by the prison despite a family request that this should not happen. His family complained to the investigating team of the lack of sensitivity in the prison conveying this information to him.

- A number of prisoners stated to the investigation team that the man was potentially being groomed on C-wing by older homosexual prisoners. A number of prisoners also reported that, since his death, the opportunities for grooming had been reduced as a result of greater patrolling of landings by staff on an evening duty. The level of patrolling prior to his death may have increased the opportunity for him to have been groomed.

- Regarding the patrolling by night officers, the investigation team is generally of the view that night officers will make a specific point of checking Category A prisoners and those on F2052SH monitoring, but that they will restrict their patrolling of landings otherwise to answering cell calls, using the pegging clock and doing security checks. It may well be that night officers need reminding of the need to patrol more widely.

- The police have suggested to the investigation team that a common feature in deaths they have investigated recently has been the use of cell windows as ligature points. The man used the top of his window as a ligature point and it might have prevented his death if there had been a mesh across his whole window enabling him to open and close the

window but denying him access to the top of the window to attach a ligature.

- No cell door log was maintained from the outset of the discovery of the man detailing all who had entered from the first point of entry of the first on scene staff. The cell door log was only commenced when the duty governor arrived.

- Similarly, the incident file maintained for the man's death included no written report by the duty governor. The investigation team had to interview the duty governor to obtain the necessary details from her.

- Finally, Wakefield's policy of requiring police to make initial contact with families to inform them of deaths certainly delayed the notification to the man's family. This was partly due to the man himself having not maintained an up-to-date record with the prison of his mother's address. However, when it became apparent to the prison that Greater Manchester Police had not been able to contact the family by the afternoon, the prison could have used his PIN phone numbers (e.g. his sister's phone number which he had used himself the previous night) to contact the family without further delay.

11 RECOMMENDATIONS

11.1 HMP Wakefield should review its Personal Officer Scheme with a view to ensuring that Personal Officers have greater contact with prisoners and make entries in the history sheet at least once per week, with a weekly management check of those entries. Furthermore they should ensure an annual check of next of kin details.

11.2 HMP Wakefield should step up the level of training it offers staff in Prisoners at Risk of Self-harm Awareness.

11.3 Staff at Wakefield should be reminded of the need to patrol robustly in the evenings to identify and eliminate bullying and grooming.

11.4 In view of the man's family's concerns about the insensitivity of the way he was notified of his grandmother's death, Wakefield should review its bereavement counselling of prisoners.

11.5 HMP Wakefield should ensure that SOTP facilitators interview candidates for SOTP in surroundings where observation by other prisoners is at a minimum.

11.6 In addition to the roll check at the beginning of his/her shift, the night patrol officer should make at least one further check on any prisoner about whom dayshift staff have expressed concern in the observation book. The Night Orderly Officer should ensure this happens.

11.7 HMP Wakefield should remind all staff discovering an emergency that if they have a radio they should use it to summon assistance, thus avoiding delays in contacting other staff or reaching a phone.

11.8 HMP Wakefield should clarify its Governor's Order 306 of 2004 to require night staff carrying sealed packs that they should be used immediately when they discover a prisoner is hanging and two staff are present, rather than waiting for Assistant Night Orderly Officer's cell keys and the Night Orderly Officer, as occurred in this case.

11.9 The night officer should also be reminded that he should have called the ECR via his radio rather than delay matters by running to the centre, also, that he should have entered the cell immediately he had assistance, using his sealed pack.

11.10 HMP Wakefield should review its cell lay-outs with a view to reducing ligature points such as the top of windows.

11.11 Critical incident debriefing for First on Scene and other involved staff should be carried out within one month of a death in custody incident at Wakefield.

11.12 Cell door logs should be maintained at Wakefield from first point of entry into the cells of any prisoners found to have died.

11.13 HMP Wakefield should ensure that death in custody incidents generate incident files which include detailed written reports from Duty Governors handling the incident and in overall control.

11.14 The Governor should remind senior managers that contact with families of deceased prisoners is not to be delayed when police have difficulty contacting relatives, and they should use their own information such as up-to-date PIN phone numbers for family members. Where possible, the prison itself should make the first contact with bereaved relatives.

11.15 The clinical review makes four recommendations, which I endorse. I attach particular importance to the third recommendation which is here restated: "HMP Wakefield should review the need for pro-active follow up of vulnerable prisoners with severe mental health problems."