Investigation into the circumstances surrounding the death of a man at HMP Hull on 3 October 2004

Report by the Prisons and Probation Ombudsman for England and Wales

January 2005

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The sad death of the man at HMP Hull was unfortunately not the first at the prison. Under transitional arrangements agreed with the Prison Service, a senior investigating officer is appointed to work directly to me and conduct the investigation, and I am pleased to concur with his conclusion that the man's state of mind was properly assessed by prison staff and that they took the correct actions when his death was discovered. His family is perplexed by his suicide and I regret that I am unable to provide any explanation for them.

The investigation team has already expressed their condolences to the man's family and I would like to take this opportunity to add mine. I hope that at least some of their questions will be answered by this report. Their concerns for the wellbeing of his cellmate and for the staff involved are appreciated.

I would also like to acknowledge the hard work of the two investigators, who carried out a thorough investigation. Their draft report has been amended only for purposes of style and their conclusions are accepted. My family liaison officer met the man's mother, fiancée and uncles and a colleague from my office liased with all involved in the investigation. I am grateful to Eastern Hull Primary Care Trust for carrying out a timely review of the man's clinical care whilst he was at the prison. Finally I thank the Governor and staff of HMP Hull for their continuing help and cooperation with this investigation. The assistance of Humberside police is also much appreciated.

The report contains one national and a number of local recommendations, particularly relating to the availability of detoxification medication at the weekend and the terms of the out of hours GP contract. However it is essential to stress that this led to only a slight delay in a doctor attending and that unfortunately the man was already dead by that time. A number of examples of good practice have also been identified, especially concerning the actions of the Oscar 2 officer and the nurse who attended the incident.

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January 2005

Summary

1. At the time of his death on Sunday 3 October 2004, the man was 25 years of age. He was arrested three days earlier on Thursday 30 September along with his fiancée. She was released the following day, but he remained in Police custody until his court appearance at the Magistrates Court on the morning of Saturday 2 October. He was remanded in custody for theft, assault of a Police Officer and obstructing a Police Officer.

2. The man arrived at HMP Hull at 12:35 on Saturday 2 October. He underwent initial interviews in the prison's Reception area before transferring with several other new arrivals to A Wing shortly after lunchtime. A Wing is the prison's First Night and Induction Wing.

3. He was interviewed by a member of the prison's Healthcare staff and an A Wing Officer. He was given sufficient credits to use the telephone and used them to ring his fiancée, at their home address at 15:23.

4. He was then shown by an officer into cell A6/9. Already present in that cell was his cell mate, who had also arrived at the prison that morning. He collected a meal and a breakfast pack for the following morning at about 16:30 and the cell was then locked for the night.

5. His cell mate informed the investigation team that they watched television together, before he went to sleep on the bottom bunk. He woke briefly during Match of the Day (scheduled between 2030 and midnight) and then went back to sleep. He slept fitfully, but was awoken by two members of the night staff (both OSGs) calling to him through the door at about 05:05 on Sunday 3 October. They asked him to locate the man, who was not in his own bunk and could not be seen by them. His cell mate saw the man seated in the toilet recess area of the cell and tried unsuccessfully to wake him. He got out of his bunk and tried again to wake him, but realised he had a ligature around his neck and informed the staff.

7. The night staff alerted others by radio. An officer attended and opened the cell door. He examined the man but could not identify any vital signs of life. The Night Orderly Officer and a nurse attended shortly afterwards and the nurse also examined him, concluding that there was nothing that she could do to help him. CPR was not attempted. Contingency Plans were activated. An ambulance crew attended A Wing at 05:36 and declared that he was dead. A police doctor also attended at 06:30.

8. The post mortem carried out on 3 October 2004 established that the cause of his death was due to hanging.

9. A Clinical Review was commissioned, to examine the medical aspects of his care whilst in HMP Hull. The author of the report is Eastern Hull Primary Care Trust.

Personal Background

10. The man was born on 15 June 1979 in Scotland. His parents separated, but were reconciled briefly at the time of his birth, separating again shortly afterwards and subsequently divorcing. The mother and her son moved into her parents' household. When he was aged five his grandfather died, followed three years later by his grandmother. At this stage he went into the care of the local authority, in which he continued until 1994. He had weekly contact with his father, but this tailed off and they had no contact for some time prior to his father's suicide in 1989.

11. The man started using cannabis in 1992/1993. He left school in 1993. The first record of his offending was in September 1994, with several court appearances in Dumbarton Courts during 1995 for a variety of types of offences.

12. There was a break in his offending until 1998, a year in which he started use temazepan. In May of that year he received his first custodial sentences, namely three sentences in a Young Offenders' Institute ranging from 30 days to six months.

13. Later in 1998 he and a friend moved to Lancashire and commenced work in a factory. Part of the reason for moving from Scotland was to distance himself from the drugs scene in Dumbarton, however he subsequently appeared at courts in Blackburn and Doncaster. At this stage almost all his offences involved shoplifting to finance his misuse of drugs, a pattern which continued for the remainder of his life.

14. In 1999 he started using heroin, and was found guilty of a charge of possession of heroin by Doncaster courts in May. In November he was sentenced to 18 months in a Young Offenders' Institute for burglary and breach of a probation order. In 1999 whilst in the custody of HMP & HMYOI Doncaster, he harmed himself by cutting his wrists.

15. He was released on license in April 2000 from HMP & HM YOI Moorland, but was recalled in July due to sporadic attendance of appointments with his supervising officer. As a result of this imprisonment he lost his accommodation.

16. His first adult custodial sentence was in September 2000 when he served three months sentence for assault, and was released a month later.

17. At court appearances in November 2000 he received sentences totalling nearly five years for a variety of offences and entered HMP & HMYOI Moorland. He remained in contact with his mother by telephone and letters.

18. By April 2002 he had transferred to HMP Channings Wood (in the south west of England), where he attended a drug treatment

programme. He was in contact with his mother and friends, but was expecting no visits and appeared "socially isolated". After completing half of the programme, he withdrew from participation. It was proposed that he be released in West Yorkshire and so he transferred back to Moorland prison. Before transfer he was assessed as being in good health (physically and mentally), settled, motivated and positive about his future.

19. His release on licence from Moorland was agreed in October 2003 and in December he began the relationship with his fiancé. Soon afterwards his licence was revoked and he returned to custody. His fiancé says this was because he "did not get on" with his Probation Officer. He returned to HMP &YOI Doncaster where he underwent detoxification from drugs but refused assistance from the Probation Service. During this sentence he wrote to his fiancé to propose marriage. There were records of poor behaviour during the sentence. He was released on 9 March 2004.

20. The relationship with his fiancé continued and they decided to move in together. His addiction to drugs continued and they used to shoplift together to fund his drugs misuse.

Establishment background

22. HMP Hull was opened in 1870 and is now a Category B local prison serving the courts in East and North Yorkshire and North Lincolnshire. Hull receives prisoners, such as the subject of this report, directly from court.

23. A major expansion programme, completed in late 2002, added 356 places to the prison's operational capacity and a further 40 places were added in March 2004. The operational capacity (the maximum number of prisoners who can be held in the prison) is 1,071 and the CNA (certified normal accommodation) is 812.

24. In March 2004, HM Chief Inspector of Prisons carried out an announced visit and reported that the prison was providing a largely safe and decent environment. Additionally, the prison has undergone a full Standards and Security Audit in 2004 and has been rated "good" in both areas.

25. A Wing contains the prison's First Night and Induction unit.

The investigation

26. Following the man's death, on 11 October, two colleagues from the Prison and Probation Ombudsman's office, as well as the investigator and assist investigator visited HMP Hull. Arrangements were made to notify staff and prisoners of the investigation and meetings took place with the Governor and representatives of the POA and IMB. The internal documents relating to the man's few hours in HMP Hull were also obtained.

27. The Ombudsman's representatives also contacted the office of the HM Coroner of East Riding and Kingston upon Hull and the investigating police representatives.

28. The Ombudsman's Family Liaison Officer contacted the man's family in Scotland and visited his mother and other family members on 22 October. The Family Liaison Officer and the investigator visited his fiancée, on 2 November.

29. The Ombudsman's office commissioned a clinical review of the man's medical care whilst in the prison from the Director of Professional Development at Eastern Hull Primary Care Trust. The Coroner's office provided a copy of the report of the post mortem carried out by a Professor of medicine. The investigating police officer, a Detective Constable provided his police custody record. I am grateful for the ready co-operation of all those involved in this process.

30. HM Prison Services' Safer Custody Group provided the investigation team with an analysis of self inflicted deaths by ligature types, an issue of concern raised by his family.

31. The investigators interviewed four prisoners and 17 staff who had contact with him during the few hours he was in the prison. Another prisoner who was in a cell adjoining cell A6/9 on the night of the man's death was released shortly after the incident. Efforts were made to trace him, but without success.

The events leading up to the death of the man

32. Whilst living in Grimsby, the man and his fiancée continued to shoplift to raise money for his drugs. At 20:30 on Thursday 30 September, both were arrested for allegedly stealing sweets and frozen food to the value of £7.44. Later he was also charged with assaulting a police officer and obstructing a police officer by giving a false identity, though this charge was later changed to attempting to pervert the course of justice. Within a short period of time his true identity was known to the police and it was also established that he was wanted by the police for failing to attend court.

33. At 08:02 on 1 October, whilst in police custody, he asked to see a doctor who attended at 15:10 that day. He was given dihydracodeine and zopiclone later in the day and two amounts of dihydracodeine the following day. These medications are prescribed to deal with drug withdrawal and related sleep disturbance. The police records include observations of the man, visits to him, food and drink given and that he made a telephone call at 14:30.

34. On the same day his fiancée was cautioned by police and released. She says that she asked the police to see him, but the request was denied.

35. After formally being charged later in the afternoon of 1 October, he undertook a drugs test via a saliva sample. The record states that he said that he had taken no medication in the past 24 hours, but had used heroin and crack (cocaine) “yesterday” (30 September). The results were positive for heroin and cocaine.

36. At 08:35 the following day, he was transferred to court by the escorting contractor (GSL). On the PER form the police alerted GSL to his risk factors, that is a history of violence, weapons and drug use (heroin). He appeared in court at 09:39 and was remanded into custody. Arrangements were made for him to transfer to Hull. At 11:26 GSL staff opened a suicide/self harm warning form, after he informed them that he “made a serious suicide attempt at HMP Doncaster five years ago. States he has not thought about self harm suicide since then. States he is addicted to heroin.” He was then transferred to Hull.

37. At 12:35 a GSL vehicle containing three prisoners, including the man, travelled from Grimsby and Scunthorpe courts and was booked in at the prison gate. The two other prisoners shall be known as Prisoner A and Prisoner B. Prisoner A met the man in Grimsby police station on the Saturday when they were in a holding cell together. He described how they talked of the man’s girlfriend in Grimsby and said that he was addicted to heroin. Prisoner A said he saw him showing the first signs of withdrawal as he shivered and had goosebumps. They chatted whilst in the cellular transport from court, but said nothing significant.

Reception

38. The man and Prisoner A continued to chat in a holding room in the reception area, where they were each given a meal, though Prisoner A thought the man may have left his.

39. The man was interviewed by an officer with 14 years experience, including two years in reception. The officer checked in any valuables and cash, searched him fully and offered him a shower. He completed his property record and started his Cell Sharing Risk Assessment (CSRA), completed his cell card and took his photograph. The Senior Officer in Reception booked him onto the prison's computer system.

40. The primary purpose of the CSRA is to assess an individual's risk to other prisoners if they were to share accommodation, but there is also some reference to the potential for self-harm. The officer described the man as being calm and polite, though not very talkative. The officer examined the PER and noticed the self-harm warning form completed by GSL staff earlier in the day. He also noticed that a form F2052SH had been opened previously and the man informed him that he was currently dependant on drugs and alcohol. He informed the officer that he would have no problems sharing a cell with someone else and was assessed as presenting a low risk when sharing with others.

41. The officer noted that the GSL Suicide/Self-Harm form had been opened due to the incident five years previously. He recorded that the man had no thoughts of self-harm of suicide and emphasised this by triple underlining the word "no". He noted that the man had an addiction to heroin and described himself as an alcoholic. His fiancée has disputed this subsequently, stating that he drank only small quantities of alcohol. It is possible that he said this as an attempt to receive detoxification medication more speedily, although this is speculation only.

42. When discussing the self-harm five years previously, the officer recalled the man telling him "look that was a load of rubbish, that was five years ago, it's in the past and I said, well look can you tell me …have you any thoughts – and it's again the way I worded it – have you any thoughts of suicide or self-harm. In other words will you try and hurt yourself". The officer then said "I remember quite clearly he said "no gov it was in the past". The officer recalled that at the time of this conversation the man "wasn't distressed, upset, he was quite calm".

43. The officer had no concerns of his risk of self-harm or suicide. In the interview with the investigation team he demonstrated full knowledge of the procedures to open an F2052SH and initiate the appropriate monitoring procedures.

Induction Unit – A Wing

44. In the early afternoon after the Reception interviews, the man and the other new receptions were transferred to the Induction Wing (A Wing). This was the first time that his cell mate met the man. During the afternoon there were further interviews and, in between, they were in a holding room where there was a television. There were four to six prisoners there including the man, his cell mate and Prisoner A. His cell mate said that he seemed "normal" and "easy". Prisoner A said that the man made a telephone call before both were transferred to their respective cells on A Wing. The man was allocated cell A6/9 and not one of the four "safer cells" as he had not been assessed as being at risk of self-harm or suicide. Safer cells are especially designed to reduce risks as their design includes reduced ligature points. His cell mate, remained separate from the others, and did not join in with their conversations.

45. Another prisoner, Prisoner C, began chatting with the man and they found they had mutual acquaintances. Prisoner C described him as talkative. He was aware that he was a heroin addict, but he did not mention withdrawing and Prisoner C did not see any signs of it. He also knew that the man collected a "smokers pack" and £1 telephone credit used to make a telephone call.

46. He was interviewed by two members of staff. The officer saw him as part of the A Wing induction. Prior to his prison service, the officer worked as a nursing assistant in a psychiatric unit. He has worked for the prison service for four years, the last two being on A Wing during which he undertook training on the Mental Health Assessment of prisoners.

47. The officer was aware of the self-harm warning form as raised by GSL staff and recalled asking him about the incident of self harm of five years earlier. He recalled that the man appeared "tired and he just wanted to go to bed". He completed with him the First Night Centre/Induction Unit Questionnaire which included a question "Do you feel like harming yourself?", with a rider "If YES, open a F2052SH". The officer ticked "No", and explained to the investigation team that he was satisfied that the man's answers to his questions were consistent with the way he presented himself. He told the first induction officer that he had not self-harmed since that incident five years before and said that he had no intentions of doing so.

48. The induction process was completed and the officer signed that he issued him with an induction leaflet, which included information about how to contact the Samaritans and the Listeners, and other basic items such as a £1 telephone credit and cutlery.

It is recommended that the contents of the induction leaflet are reviewed, as the print is small and the contents, especially of the initial pages, is complex and not of immediate relevance to those who may be at risk.

It is good practice that induction leaflets are issued routinely to prisoners on their arrival.

49. The officer completed the induction interviews and attended the landings to assist unlocking the prisoners for the tea meal. He did not recall seeing him again that day. The following day he was asked by the police to identify his body in cell A6/9.

50. Some time after the interview with the induction officer, the man was also interviewed by a Staff Nurse. The Staff Nurse is not a direct Prison Service employee, but works for Eastern Hull Primary Care Trust. He has worked within the prison since March 1994, and previously for two and a half years as a G Grade Nurse in a Community Drug and Alcohol Team. He qualified as a Psychiatric Nurse in 1994 and is also a Registered Mental Nurse.

51. The Staff Nurse completed the First Reception Health Screen form, which assesses prisoners' medical and mental health needs. He recorded that the man declared acute alcohol and heroin misuse, but it did not record that he also used cocaine, as identified the day before when he was in police custody. The man's father's suicide was also recorded, as was the self-harm episode of five years earlier. The Staff Nurse recorded that he appeared to be fit and healthy, but was noted as being referred to a doctor due to his substance misuse.

52. On Saturday the doctor only attends the prison during the morning and so the first opportunity for the man to have been seen would have been the following day, Sunday 3 October. Any medication prescribed to assist his withdrawal from drugs and alcohol would not have been dispensed until later that day, or Monday 4 October. He had been in police custody since the evening of 30 September. He received some medication, including dihydracodeine at 05:30 and 07:35 on 2 October, whilst in their custody. On entering prison custody it would have been well in excess of 24 hours before being assessed for further medication.

It is recommended that the weekend arrangements for assessing and dispensing detoxification medication are reviewed.

53. The section of the First Reception Health Screen form relating to mental health should have recorded the need for a referral for mental health assessment. However this did not impact detrimentally to the man who died as a doctor would not have been available to see him until later on Sunday 3 October and drug workers would not have been available until Monday 4 October at the earliest.

The incorrect completion of this form is addressed as learning point within the Clinical Review.

54. The Staff Nurse then completed section three of the CSRA, assessing him as a low risk to others and stating that no concerns had been

raised following the self-harm assessment. The Suicide/Self Harm Warning form (box 8) was signed by the Staff Nurse at 15:15 on 2 October, and was effectively closed as the question whether "F2052SH (or ACCT) opened" was answered in the negative.

55. The man was described by the Staff Nurse as not being overly anxious or distressed during the interview and said that he gave him no major cause for concern. He was lucid, was not negative about his circumstances and did not show signs of serious alcohol withdrawal symptoms.

56. He was allocated cell A6/9 by the Movements Officer. As neither the first induction officer nor the Staff Nurse notified any problems about him, the allocation would have been based on the information on the cell card, that is his name, number and that he was held on remand.

57. At 15:23 on 2 October the man used his telephone credits to contact his fiancée, the call lasting six minutes 41 seconds. The tape of the conversation was listened to by the investigating team who were of the opinion that he did not sound distressed or concerned. His fiancée described him as seeming "happy". He confirmed that he was in Hull and was due to appear in court via videolink on the following Wednesday, and expected to be transferred to HMP & HMYOI Doncaster shortly afterwards. The call continued with the man talking to his fiancée's sister and discussing how they were going to visit and send some money in. He informed her that he would not be receiving detoxification medication until the Sunday, and she advised him not to take his medication all at once. Towards the end of the conversation he told his fiancée that he would be writing to her that night but this letter has not been found.

58. The man's cellmate had been allocated and entered cell A6/9 before the man arrived there. He had discovered that the kettle and television needed to be replaced, and had organised this by the time the man arrived some 45 minutes later, between 16:00 and 17:00.

59. Prisoner A had been aware that the man collected his meal and breakfast pack but, as it would have been eaten in his cell, he did not know whether he ate it. Prisoner B and Prisoner D were located in cell A6/10, next door to A6/9. The only time Prisoner B saw him was when he saw him enter A6/9 with his tray of food and take the upper bunk. His cell mate said that he "seemed alright", but that he was worried about coming off drugs. His cell mate confirmed that he ate his meal, and that he ate his breakfast pack at this stage as well.

60. After the man and his cell mate collected their meals and breakfast packs, the cell door was closed, no specific member of staff having been identified as doing so. Each cell on A Wing, including A6/9, had Samaritan contact details stencilled on the cell wall.

The investigation team commend the prison for giving prisoners on the First Night Centre the Samaritans' contact details in this way.

61. Shortly after 16:30, the Duty Governor, followed routine practice and examined the man's CSRA and noted that there were "No current SH [self-harm] issues, can cell share."

The investigation team recognise the good practice of the Duty Governors examining all CSRAs and recording their comments routinely.

62. Prisoner A told the investigation team that he heard the emergency cell bell sound repeatedly through the evening, and thought it might have been the man who is the subject of this report sounding it, but said that he could not be certain of this. Neither Prisoner A nor Prisoner B heard anything untoward during the night and they found out about the man's death later the following day.

63. His cellmate stated that the man was restless, that he was "up and down a lot…just getting up and not doing a lot really". A lot of noise was caused by other prisoners talking from their windows, but he said that the man did not join in. His cell mate said that the man told him that the noise was "doing his head in". They watched television together during the evening. His cellmate fell asleep, waking to watch part of the Parkinson Show together and laughing at some of the content. They then turned over channels to watch Match of the Day, beginning at 22:00. His cellmate again fell asleep, waking only briefly during the programme when he said that the man was still awake at this point, and he fell asleep again. At some point in the night his cellmate woke up, saw the man sitting in the toilet recess and asked if he was alright. He got no reply and assumed he was asleep. His cellmate then slept restlessly until he was woken by staff at about 05:00. He said that he was not aware of the man sounding their emergency cell call bell during the evening or night.

64. Two Wing officers completed a full count of prisoners on A Wing at about 16:30 and again between about 19:00 and 19:15. The first Wing officer could not recall any contact with the man during the evening. The second Wing officer named another prisoner from opposite to A6/9 who he believed was using his emergency cell call bell frequently during the evening. The emergency cell call bell system on A Wing does not include a facility to identify which cell bell has been sounded. The two officers handed over to two OSGs, all stating that there was no information of particular significance in the handover.

65. The two OSGs carried out a further roll check of prisoners at about 20:30. A Response Officer was also located on A Wing during that night. He carried radio call sign Oscar 3 and as such, was not allocated a cell key.

66. During the night period neither OSGs recall being called to cell A6/9. They carried out periodical patrols, which were recorded by means of an electronic device called a pegging gun. The Night Orderly Officer (NOO), a Senior Officer, was responsible for checking these records the following day, before passing them to the Duty Governor. The NOO found no anomalies or inaccuracies with the pegging records for A Wing on the night of 2/3 October 2004. The investigation team have also examined these records and have no concerns with them.

67. Neither OSG recalls being called to cell A6/9 during the evening of 2 October or the night of 2/3 October, either by the emergency cell call bell being sounded or otherwise. At the time of the incident the cell call bell system did not provide a record of which cell had rung their bell. It is good practice that the prison is currently considering installing an addressable call bell system in the planned refurbishment of A wing. None of the prisoners in the adjoining cells to A6/9 who spoke to the investigation team, recalled hearing anything untoward during that night. The cells below A6/9 were unoccupied that night and A6 landing is the top landing on that part of the wing.

The incident

68. At about 05:00 both OSGs commenced a full physical count of prisoners on A Wing. This was in line with the guidance in the "Night Patrol Information Pack" for A Wing (effective from 1 August 2004) which states that:

1 There will be two routine roll checks at night, conducted by Night Staff. These will be:
i) At the commencement at duty (at 2115 hrs)
ii) Before day staff commence (at 0630 hrs)."

69. Staff informed the investigation team that it was usual to start this check from 05:00. On 3 October the OSGs started their check at the end of A Wing furthest away from cell A6/9, each taking one side of each landing and on reaching landing A6, the first OSG checked the side including A6/9**.** The statements completed by these staff were identical and, therefore, not entirely accurate.

It is recommended that staff at the prison give their own individual account of events when making statements after an incident.

70. When he reached A6/9. the first OSG opened the observation hatch on the door to look in, he could not see the occupant of the top bunk and so called the second OSG across from the other side of the landing. The second OSG knocked on the door and called out to wake up the man's cell mate. The first OSG moved to the observation point (spyhole) which gives enables staff to see into the toilet recess area of the cell. The first OSG stated that he could not see the man at the centre of this investigation, as the vision was not sufficiently clear and the light was insufficient to see him.

71. The man's cell mate told the investigation team that he was woken by staff shining a torch through the observation hatch, putting on the nightlight (in the cell) and being asked where his cellmate was. The first OSG informed the investigation team that the night light (which can be turned on by staff from immediately outside the cell) was insufficient to allow him to see the man, as it is not as bright as the in-cell light, which can be operated only from within the cell.

72. The investigation team found that the OSGs acted in accordance with the current guidance at the prison. The Night Patrol Information Pack states:
2 Roll checks are conducted to ensure:
i) That the roll is correct
ii) That every prisoner is in the correct cell

3 Night staff must assure themselves that prisoners are in the cell by obtaining a clear view of them – if necessary by waking them.

73. His cell mate tried to wake the man by reaching from his bunk and nudging him with a chair. He could only see his legs as the wall between the toilet recess and the cell/sleeping area juts out slightly. He failed to get a response, and was asked by the second OSG to get out of bed, switch on the in-cell light and wake him up. The cell mate complied with the instruction. He informed the second OSG that he appeared to him to be dead and had hung himself as his cell mate had seen a lace leading from his neck to, what he thought, were the window bars. The man was wearing a t shirt and boxer shorts.

74. The second OSG held a cell key in a sealed pouch but did not use it to effect entry into the cell and both OSGs stated that they did not use it to enter the cell because, being OSGs, neither were C&R trained. The cell was double occupancy and one of the occupants was visible and mobile. On the grounds of personal safety, the investigation team view this decision as appropriate.

75. The first OSG tried to radio for assistance, but the battery on his radio failed immediately and the second OSG used his instead. The message was timed on the log kept by the Control Room operator at 05:15. There are varied accounts of the content of the radio message, but it was sufficient to alert other staff to the incident. The second OSG states he used the term “Code Blue” in the message which is a recommended “traffic light” system to alert staff that the incident includes a person who is in difficulties with breathing, including incidents of suspension and enables them to respond with the appropriate equipment. No other members of staff recalled hearing the term “Code Blue” in the message.

76. One member of staff stated that he heard the term “we’ve got a swinger” or “someone’s swinging” but the second OSG denied that he would use either term and no other staff say they heard either term, most saying that the message was indistinct. The NOO told the investigation team that the Control Room operator interrupted the message to inform him that there was an incident on A Wing.

It is recommended that all staff at HMP Hull use the correct terminology and avoid inappropriate terminology when broadcasting radio messages.

76. The second OSG stated that the A Wing Response Officer attended “within seconds” of the radio message. Within a minute the Oscar 2 officer arrived from D Wing and as Oscar 2 he carried a cell key. The Oscar 2 officer failed to get a response from the man by calling through the door and could not see him via the toilet recess spyhole or observation hatch. He was the first officer to enter the cell. He saw the man’s cell mate sat on the bottom bunk and appearing in shock and the man in a seated position in the toilet recess area, under the window at the back of the cell.

77. The Oscar 2 officer saw a ligature from around the man’s neck to the window catch above, and he lifted his body up slightly and cut the

ligature. He checked him for vital signs – breathing, pulse and heartbeat, but found none present. He described to the investigation team the discolouration of his body and initial indications of rigor mortis. He noticed a training shoe near to him had a lace missing and rechecked the ligature and realised that it was a lace.

78. The Oscar 2 officer and others described that he was seated in the toilet recess area, under the window with his legs stretched out straight in front of him. Initially the Oscar 2 officer prevented other staff from entering A6/9 in order to preserve evidence.

79. The NOO heard the radio message from the second OSG. As it was indistinct, he was contacted by Control Room staff to inform him of an incident on A Wing. He contacted the nurse by telephone and, as nurses do not carry keys during the night duty period, he arranged for her to be collected by a member of the response team. He then attended A6/9 and at 05:15 he and the Oscar 2 officer were joined there by the nurse.

80. The nurse examined the man and concluded that there were no vital signs and, given the appearance of his body, that there was nothing more she could do for him. She comforted his cell mate, who was still seated on the bottom bunk and visibly distressed.

The investigation team considers that the decision by the Oscar 2 officer and the nurse not to attempt CPR was in accordance with the prison's guidance, which states *…In cases where death has occurred sometime prior to discovery and rigor mortis has set in e.g. body stiff, dependant discolouration etc. resuscitation should not be attempted.*

Staff involved in dealing with the incident are to be commended for their speedy response.

81. The NNO allowed the man's cell mate to get dressed and he was moved to another cell on the same landing, the nurse accompanying him and arranging for a hot drink to be provided. Within a few minutes he was transferred to B Wing and located in a cell with two Listeners for support.

The investigation team consider that the support given to the man's cell mate was sympathetic and entirely appropriate.

82. However in allowing the cell mate to dress in his own clothing and move cells potentially compromised the preservation of evidence. The NOO described that he could not preserve his clothing as he had no access to evidence bags of an adequate size.

It is recommended that the NOO's office is supplied with an adequate stock of varying sizes of evidence bags. Cell A6/9 was treated by the police initially as a crime scene.

83. The NOO and the Oscar 2 officer went out of the cell. The Oscar 2 officer commenced a log of those attending the scene and the NOO began the activation of the prison's relevant Contingency Plans.

The investigation team acknowledges the commendable actions of the Oscar 2 officer. He acted entirely appropriately in applying the actions in an attempt to preserve life and in the preservation of evidence.

84. The nurse remained near A6/9 and briefed the two paramedics who arrived on A Wing at 05:36. They entered the cell and informed the nurse shortly afterwards that there was nothing they could do for the man who is the subject of this report. The nurse then left and returned to the Healthcare Centre.

Post Incident

85. Following the prison's contingency plans, a doctor was contacted and requested to attend. At the time of the incident the doctor cover was provided by a locum service, and the doctor on call refused to attend the prison. However a police doctor was contacted and attended at 06:30. Other police officers attended from 05:50.

It is recommended that the agreement with the locum service is reviewed as a matter of priority and that a specific condition that a doctor is required to attend the prison in such circumstances is included.

86. The Staff Care Team representative arrived on A Wing at 06:20, an Independent Monitoring Board member at 06:50 and the Duty Governor at 06:53. The man was identified to the police by an A wing officer at 08:30.

87. At 08:20 prisoners on both sides of A6/9 were relocated to alternative accommodation on the wing. Of the prisoners interviewed by the investigation team, none had been aware of the nature of the incident until later in the day.

88. At 10:04 undertakers attended and removed the man's body from the prison and the cell was again secured.

89. Notices to inform staff, prisoners and visitors of the man's death were issued later on 3 October by a prison governor.

Family contact

90. Attempts were made to contact the man's relatives. He had provided the telephone number and an incomplete address for his next of kin, his mother. However the telephone number gave a "discontinued service" tone. The man's fiancée was listed as a further contact at their address in Grimsby and she was visited by the police that afternoon and informed of his. She had no contact details for his mother, who was traced by police and informed on 4 October.

91. The Governor of Hull wrote to his mother and fiancée offering condolences and providing contact details on 5 October.

92. The man's mother asked the prison to communicate with one of the man's uncles and this was undertaken by a prison governor, who also kept in touch with his fiancée, until the Ombudsman's Family Liaison Officer took over responsibility for family contact.

Support for staff.

93. Generally staff involved were supported by the Duty Governor and the Staff Care and Welfare Team after the incident and a “Hot” debrief was held by the Duty Governor. The staff informed the investigation team that they felt adequately supported.

Specific concerns represented by the man’s family

95. Through their communication with the Family Liaison Officer, the man’s family raised a number of matters, which are listed below together with the findings of the investigation:

* concern about the wellbeing of his cellmate and the prison staff involved in the incident, issues which have been covered earlier in the report

* they asked why he was not on a “suicide watch”.
In the short time that he was in the prison he was assessed in some depth by three separate members of staff, all of whom were suitably experienced and qualified. None of the staff identified that he presented a particular risk of self-harm or suicide. This was ratified on the CSRA by the Duty Governor. Consequently, it was appropriate that he was allocated a standard shared cell with another prisoner. Also he had talked to several other prisoners whilst in police custody and the prison, several of whom had been in custody previously. None of those prisoners thought he was at particular risk.

* it appears that he used a shoelace, possibly from a training shoe, as a ligature and some of his family believed shoelaces were removed from prisoners upon arrival.
When this question was asked it was explained that laces are not routinely taken from prisoners. He had not been found guilty of an offence and was held on remand and so entitled to wear his own clothes and footwear. He chose to wear prison clothing with his own trainers.
Subsequent enquiries of Prison Service Headquarters give further reasons for not routinely removing shoelaces include:

- removal of shoelaces (or other items) could displace the means of suicide to other materials
- many prisoners might find removal of such items distressing and humiliating
- the attention of other prisoners could be drawn to vulnerable people, by the absence of shoelaces or other items, whose distress would then be worsened
- knowledge by prisoners that admission of suicidal feelings would result in removal of items might discourage such prisoners from seeking help.

* his family requested details of other materials known to be used as ligatures.
  HM Prison Service have data indicating that bedding is the most common material used as a ligature. Between 1999 and 2004 bedding was used in this way in an average of 67% of self-inflicted deaths by suspension and shoelaces in 17%. The other specified ligatures include clothing and belts.

* his family asked what other potential ligature points are in prison cells.
  As well as window catches, there are other potential ligature points in standard cells, including window bars, taps, tubular metal bed-ends, cell door hinges and light fittings.
  HM Prison Service is converting some cells into "safer cells" with a reduced number of ligature points. A Wing has four such cells, all designed for single occupancy. As he was not identified as at risk of suicide or self harm, he was not located in a "safer cell".

  It is recommended that the Prison Service reviews the provision of "safer cells" on the First Night/Induction unit at HMP Hull, to establish whether it is feasible and desirable to provide double occupancy safer cells in that area.

  It is also recommended that the draft First Night Centre Policy Document is formally introduced and publicised as soon as practicable, as some staff remained confused as to the purpose of the safer cells on A Wing.

The post mortem

96. A copy of the post mortem report is attached as an annex to this report.

97. The post mortem was conducted on 3 October and concluded that the cause of the man's death was by hanging. Opiates (which include heroin), morphine, dihydracodeine and a trace of cocaine were detected in his body, but it was concluded that the drugs did not contribute to his death.

The Clinical Review

98. A review of his medical care whilst in custody was undertaken by Eastern Hull Primary Care Trust and a copy of her report is attached as an annex to this report.

99. The clinical review addressed six specific questions, which are listed below together with the findings:

- Why was a suicide self harm form opened by the police?
  It was actually opened by the escorting contractor's staff (GSL).

- Was this due to the history of self harm five years ago?
  Yes.

- On suicide self harm form Q5 what does intermittent observation mean?
  This is not relevant in his case as such a form was not opened. Observation frequency is normally specified in the documentation in form F2052SH or, if the circumstances of an individual case require a different frequency, it should be specified.

- First reception health document completed by a nurse, but what qualifications does he possess?
  The nurse's qualifications and experience is explored earlier in this report.

- Action Plan section states referral for substance misuse, but does not state as to when this should occur.
  This was due to completed once the man saw the doctor, due on Sunday 3 October.

- What provision had been made to ensure that he was managed during his withdrawal from both drugs and alcohol?
  This is dealt with earlier in this report. The follow on care was due to be formulated when he saw the doctor which was due on Sunday 3 October.

100. Four learning events were identified in the Clinical Review:

- That notes should be clearly written, signed, timed and dated. The person writing the notes should also print their name and designation.

- The documents require to be fully completed and if deviating from instructions then reason why stated on the record.

- When recommendation is for onward referral details of this require to be recorded.

- Identified follow on care to be documented.

Operational issues

101. Following major incidents a Post Incident (Operational) debriefing should be carried out. No such debriefing took place following the man's death and there appears to be no provision for such a debriefing in the prison's contingency plans.

It is recommended that the prison's contingency plans are amended to include provision for Operational debriefings to take place following major incidents.

Findings & conclusions drawn from the investigation

102. I am satisfied that the man who is at the centre of this report was assessed appropriately regarding his potential risk of self-harm and suicide. In the few hours he was at Hull, he had considerable contact with several staff and other prisoners. He underwent three interviews by experienced staff during which his risk was assessed. The evidence is that he presented no signs which require the commencement of self-harm or suicide monitoring procedures or the need to locate him in anything other than a standard shared cell.

103. This is reinforced by several other prisoners who had contact with him during this period, all of whom were surprised and shocked at the news of his death. As well he spoke to his fiancée and her sister during the Saturday afternoon. His tone of voice, general demeanour and the conversation about future events gave no rise for concern.

104. The man's cellmate gave a detailed account of their interaction during the late afternoon and evening period of 2 October, which gave no indication that he was particularly upset, unwell or distressed. There are no indications that he tried to alert staff during the evening or overnight. He left no written indications of his state of mind at this time.

105. He had expressed concerns about receiving a long sentence this time, and knew that he was due to appear in court (via videolink) on Wednesday 6 October. He had previously told his fiancée of his worries that, should he get a lengthy sentence, she might not wait for him. He was also concerned that he had a chronic and acute drug problem.

106. There are concerns regarding the lack of provision of assessment and dispensing of detoxification. He received medication whilst in police custody but, because he arrived at the prison on Saturday morning, there would have been a lengthy delay before he would be assessed for medication and a further delay for it to be dispensed.

107. The action of the staff attending the incident was appropriate. The OSGs rightly did not enter the cell and did raise the alarm. Staff attended very quickly and an ambulance was called, which also came promptly. The Oscar 2 officer showed commendable presence of mind in checking for the man's vital signs of life and taking action to preserve evidence, to the extent that he commenced a log of those entering the cell. Both he and the nurse decided not to attempt CPR and, given their description of the appearance of his body, this was in line with the prison's guidance.

108. The prison's contingency plans were correctly put into operation. With one exception, all staff interviewed said they were adequately supported. I also consider the care and support extended to the man's cell mate to have been appropriate.

Recommendations and good practice

National Recommendations

1. The Prison Service should review the provision of “safer cells” in the First Night/Induction unit at HMP Hull to establish whether double occupancy safer cells are feasible and desirable.

Local Recommendations

2. The induction leaflet should be reviewed as the print is small and the contents, especially of the initial pages, is complex and not of immediate relevance to those possibly at risk.

3. The arrangements for assessing and dispensing detoxification medication at the weekend should be reviewed.
From arrival at the prison it would have been more than 24 hours before the man would have been assessed for such medication.

4. The First Night Centre Policy Document should be implemented as some staff remained uncertain as to the purpose of the safer cells on A Wing.

5. Staff at the prison should be reminded that individual statements must be made following an incident.

6. All staff at the prison should use the correct terminology and avoid inappropriate terminology when broadcasting radio messages.

7. The NOOs’ office should be supplied with an adequate stock of varying sizes of evidence bags.

8. The agreement with the locum service should be reviewed as a matter of priority and include a specific condition that a doctor is required to attend the prison in circumstances such as these.

9. The prison’s contingency plans should be amended to include provision for Operational debriefings following major incidents.

11. The learning events identified in the Clinical Review should be used to improve practice:

- Notes should be clearly written, signed, timed and dated. The person writing the notes should also print their name and designation.

- The documents require to be fully completed and if deviating from instructions then the reason why should be stated on the record.

- When a recommendation is for onward referral, details of it must be recorded.

- Identified follow on care must be documented.

Good practice

12. The method of providing prisoners on the First Night Centre with Samaritans' contact details by stencilling the information on interior cell walls is good practice.

13. The decisions by the Oscar 2 officer and the nurse not to attempt CPR were appropriate and in accordance with the prison's guidance, which states *"…In cases where death has occurred sometime prior to discovery and rigor mortis has set in e.g. body stiff, dependant discolouration etc. resuscitation should not be attempted."*

14. The actions of the Oscar 2 officer were commendable. He acted entirely appropriately in attempting to preserve life and preserve evidence.

15. The support given to the man's cell mate was sympathetic and entirely appropriate.

16. It is good practice that induction leaflets are routinely issued to prisoners on arrival.

17. It is good practice that Duty Governors examine all CSRAs and routinely record their comments.

GLOSSARY OF TERMS

ACCT	Assessment, Care in Custody and Teamwork (a revised monitoring system for those at risk of self harm/suicide – not yet introduced in HMP Hull)
CARATS	Counselling, Assessment, Referral, Advice & Throughcare Service (for prisoners with substance misuse problems)
CC	Crown Court
Comm Service	Community Service
Contingency Plan	An emergency plan of action following a serious incident
CPR	Pertaining to Chest (Heart and Lung) resuscitation
C&R	Control & Restraint
CSRA	Cell Sharing Risk Assessment
DC	Detective Constable
Detox	Detoxification
DTTO	Drug Testing and Treatment Order
EMT	Emergency Medical Technician
F 2050	Prisoners Main Core Record
F 2050a	Prisoners Wing Record also called History Sheet
F2052SH	At Risk of Self Harm Record
F2169	First Reception Health Screening Form
FTS	Failure to Surrender (to Court)
Gov/Governor	Governor (Senior Managers), Graded A-F
GSL	Global Solutions Limited (contracted escort service)
HCO	Health Care Officer
HCSO	Health Care Senior Officer
HMP	Her Majesty's Prison
HMCIP	Her Majesty's Chief Inspector of Prisons
HMYOI	Her Majesty's Young Offenders Institution
Hotel	Radio Call Sign for medical staff
IEP/IEPS	Incentive and Earned Privileges (Scheme)
IMB	Independent Monitoring Board (was Board of Visitors)
IMR	Inmate Medical Record
JR'd	Judge's Respite (convicted but unsentenced)
Juv	Juvenile
Listener	A prisoner trained by the Samaritans to provide support to other prisoners
Mags	Magistrates (Court)

MC	Magistrates Court
MHIRT	Mental Health In-Reach Team
MO	Medical Officer (doctor)
NOO/Night Orderly Officer	Member of staff in charge of the prison at night
NoK	Next of kin
Observation Book	A general compilation of staff observation of prisoners in a particular area
Off/Officer	Prison Officer
Oscar 1	Radio call sign for the Night Orderly Officer
OSG	Operational Support Grade
Pegging	A system allowing managers to check whether a Night patrol has patrolled their area during the night
PER	Prisoner Escort Record
PO	Principal (Prison) Officer or Probation Officer (in context)
POA	Prison Officers' Association
PPO	Prisons and Probation Ombudsman
PSI	Prison Service Instruction
PSO	Prison Service Order
Remand	Prisoner held in custody before conviction
Roll check	A visual check and count of all prisoners
SO	Senior (Prison) Officer

List of Annexes

1	Terms of Reference
2	Post mortem report
3	Clinical review report