

**Investigation into the circumstances surrounding
the death of a man at HMP Featherstone
on 30 December 2008**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

The man died at HMP Featherstone on 30 December 2008. He was just 21 years old. He was found hanging in his cell by the night staff at approximately 00.15am.

I offer my sincere sympathy and condolences to his family and friends, and everyone affected by these tragic events.

The investigation into the circumstances of the man's death was conducted on my behalf by a colleague, Investigator C. My thanks go to the Governor of Featherstone and his staff for their assistance. South Staffordshire Primary Care Trust was asked to carry out a review of the man's clinical care and I am grateful for their contribution to my investigation.

During his time in custody, he had been involved in numerous altercations and incidents with staff and fellow prisoners. He had spent time at a number of prisons but was yet to engage in any offending behaviour courses at the time of his death. At Featherstone, he became more agitated when a mobile phone that he had illicitly procured was stolen from him. He had been using the telephone to contact his partner and did not cope well with its theft. Rumours on the wing appear to have added to his distress, and on the night of his death he sought to contact his partner repeatedly but was unable to.

Although the man was often angry and behaved poorly, this can often mask issues relating to self-harm. Towards the end of his life he became more volatile, but there were no explicit indications that he would imminently harm himself again. Nevertheless, as I note in my concluding words to this report, he evidenced many of the known risk factors in prison suicides. He was a disturbed young man with a history of self-harming by ligature. He had spent much time in segregation, and been transferred from jail to jail. He was worried about his relationship with his partner, and was in conflict with other prisoners. He had stopped using mood-altering medication.

I make six recommendations regarding medical records, courses, follow-up appointments, cell fittings, resuscitation and the training of family liaison officers. I must apologise for the delay in issuing this sad and important report.

Jane Webb
Acting Prisons and Probation Ombudsman

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SUMMARY

On 11 June 2007, the man was arrested on suspicion of serious offences and was subsequently sentenced to six and a half years imprisonment. During his initial time in police custody and in the court cells, he made two attempts to harm himself. When he arrived at HMYOI Glen Parva on 13 June, he was judged to be at risk of harming himself and was provided additional support using the process known as ACCT (Assessment, Care in Custody and Teamwork). His behaviour throughout this time was disruptive and he was involved with fights with other prisoners, a pattern that persisted throughout his time in custody.

On 21 October 2007, he was transferred to HMYOI Swinfen Hall. He remained disruptive and spent long periods of time in the Care and Separation Unit. He was prescribed anti-depressant medication. On 25 March 2008, he made an attempt to hang himself. He was monitored using ACCT procedures and was referred for a place on an Enhanced Thinking Skills course (a general offending behaviour programme exploring problem-solving skills).

He was transferred again on 5 July, this time to HMYOI Brinsford. Whilst at Brinsford, he was again referred for a course to help him with his temper. On 23 July, the man tied a ligature around his neck and the ACCT process was begun again. He was referred to a doctor who prescribed Quetiapine, an anti-psychotic drug normally used for the treatment of schizophrenia or bipolar disorder. The doctor planned to review the man's response to this medicine a week later but he was transferred from Brinsford to HMP Hewell on 19 August. He continued with his medication but remained disruptive and continued to challenge authority. He never managed to attend a programme to help him with his behaviour because of a lack of available courses and his moves between prisons.

The man only stayed at Hewell until 7 October when he was moved again, this time to HMP Featherstone where he remained until his death. Staff in the Safer Custody Team at Featherstone were alerted to his history of self-harm and suicide attempts.

The man engaged in a heated argument with another prisoner on 21 December 2008 over the theft of a mobile phone that he had illegally procured in the prison. Over the Christmas period the man became increasingly agitated. He said that his mother and partner were receiving abusive phone calls and text messages, which he believed were made by another prisoner.

On 29 December, the man had a lengthy telephone conversation with his partner during which they argued about their relationship, although the call ended with them saying that they loved each other. He later made a further 23 attempts to speak to his partner but was unable to do so. On the final call at 7.42pm he left an angry message on the answerphone. He returned to his cell and was locked in for the night.

At 00.15am that night, He was found suspended by a ligature from a light fitting. Staff cut him down but there were no signs of life. He was confirmed dead at 1.10am on 30 December.

My report contains six recommendations.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened on 31 December 2008 when my colleague, Investigator A, visited HMP Featherstone. Investigator A met the Governor and the Deputy Head of Residence. He also met someone from the Independent Monitoring Board, and held a discussion with a member of staff from the Prison Officers' Association. Investigator A then went to Cell 18 in House 5 where the man had died. Notices were put up in the prison inviting any staff or prisoners to speak with my investigator. No one came forward as a result of these notices.
2. Following this visit Investigator A briefed another investigator, Investigator B, who then took over the investigation. Investigator B reviewed an initial bundle of papers sent to him from Featherstone in preparation for his visit there on 20 January 2009. Investigator B met the Governor before being taken to House 5 by the Deputy Head of Residence. There they met the staff and had a general discussion about the running of the House and memories of the man and the events leading up to his death. One of the staff, Officer A, was present when the man was found hanging and helped to cut him down. Officer A took Investigator B to Cell 18 and described what he had found.
3. The Clinical Governance Manager for South Staffordshire NHS Primary Care Trust conducted a clinical review of the man's health needs and care.
4. One of my Family Liaison Officers spoke to the man's partner and also to his mother. His partner raised several matters for the investigation to consider. She was concerned to know why he had not been subject to suicide prevention processes prior to his death, and wished to have further information on some of his property. These concerns were followed up in a letter from her solicitor and I hope that they are addressed in this report.
5. The report was subsequently completed by another investigator, Investigator C. Investigator C went to Featherstone on 5 October 2009 to conduct further interviews. He also asked the clinical reviewer and Featherstone to provide additional information.
6. Following the publication of the draft report, the man's partner questioned why it had taken so long for my office to interview staff. The initial investigator did conduct informal interviews but these were not written up. I would like to apologise for the length of time this investigation has taken.

HMP FEATHERSTONE

7. HMP Featherstone is a category C closed training prison for adult men situated about six miles north of Wolverhampton. It holds a maximum of 679 prisoners. The prison was built in 1976 and adjoins Brinsford Young Offenders Institution.
8. Featherstone has seven houseblocks. House Four is classed as normal location and House Five is the induction and reception unit. The man was a resident in both of these Houses during his time at Featherstone.
9. South Staffordshire Primary Care Trust commissions the health services for prisoners at Featherstone. The healthcare department offers a wide range of primary care services, including health promotion and the management and treatment of long term and acute medical conditions. Featherstone has no inpatient facility and the health services are not available 24 hours. An independent provider of primary care services provides out-of-hours services on behalf of the NHS.
10. Shropshire and South Staffordshire Foundation NHS Trust provides specialist mental health care to the prison. The Mental Health In-Reach Team comprises Community Psychiatric Nurses (CPNs) and a consultant psychiatrist. The CPNs work closely with the primary care nurses and doctors to assess prisoners with potential mental health problems. However, in its report for 2007-08, the Independent Monitoring Board observed that mental health referrals had increased and that missed appointments for mental health referrals were not pursued.
11. The Psychology Department provides programmes to help prisoners to address their problems. These include Enhanced Thinking Skills (ETS) and Anger Management courses.
12. In common with all other prisons, Featherstone uses a documented process to monitor and support prisoners assessed to be at risk of suicide or self-harm. This is known as Assessment, Care in Custody and Teamwork (ACCT). Once ACCT processes are begun, the prisoner is observed at intervals determined by his perceived level of risk.

Care and Separation Unit

13. The Care and Separation Unit is used to hold prisoners who are segregated from others. This may be as a result of breaching prison discipline or to protect them from other prisoners. When a prisoner is brought into the Care and Separation Unit certain procedures must be carried out. These include the completion of an Initial Segregation Safety Screen and the beginning of a segregation history sheet.

Control and restraint

14. Staff are authorised, where necessary, to use “control and restraint” techniques which involve the use of reasonable force.

Incentives and earned privileges (IEP) scheme

15. The IEP system is intended to encourage and reward good behaviour in prison. Prison Service PSO 4000 describes it as follows:

“The IEP scheme complements the discipline system by rewarding good behaviour. In addition to any local aims, it is intended to encourage prisoners and YOs [young offenders] to behave responsibly, to participate in constructive activity, and to progress through the system. This will foster a more disciplined and controlled, and therefore safer environment for prisoners and staff. It should also contribute to the reduction of re-offending by encouraging prisoners to lead law-abiding, productive and healthy lives.”

16. Prisoners are able to move up a level (basic, standard or enhanced) and earn various privileges. Poor behaviour can result in moving down a level or losing privileges. Privileges include association time and extra visits.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) made up of members of the community. The Board’s role is to ensure that the prison is properly run and that prisoners are treated decently. Each Board produces an annual report for the Secretary of State. The most recent report from the Featherstone IMB covers the period April 2008 to March 2009.
18. The IMB was concerned that the demand for places on the Enhanced Thinking Skills (ETS) and Anger Management courses outstripped the number of places available.

Her Majesty’s Chief Inspector of Prisons

19. Her Majesty’s Chief Inspector of Prisons undertook an inspection of Featherstone from 20 – 24 October 2008. In her report, she described Featherstone as a “... reasonably safe, respectful and purposeful prison”. The report mentioned that staff-prisoner relationships were generally good although there were some prisoners with very negative views of staff.
20. Safer custody procedures were generally judged to be of an encouraging standard, although further work was needed to tackle

Previous deaths at Featherstone

21. Featherstone experienced two other self-inflicted deaths in 2008. Both of these deaths involved prisoners hanging themselves in their cells. In an investigation report into one of the previous deaths, I highlighted the issue of missed appointments for mental health referrals not being pursued. I return to this issue in this report.

KEY FINDINGS

22. The man was arrested on suspicion of serious offences on 11 June 2007 and spent time in police cells and a court cell. During this period he harmed himself on two occasions.

HMYOI Glen Parva

23. After his arrest, the man was received into HMYOI Glen Parva on 13 June 2007. The ACCT process was begun the same day as he had harmed himself in police and court custody. The man was also low in mood as he realised the seriousness of his offences, and anticipated a significant custodial sentence. He later told staff that, although he had harmed himself, he did not want to die as his partner was expecting his child. Although staff acknowledged his statements that he would not harm himself, they decided to maintain the ACCT processes until the outcome of his court appearance on 21 June was known.
24. The man was found guilty of the charges he faced on 21 June and was remanded to Glen Parva to await sentencing. He asked for the ACCT process to be ended and it was closed.
25. However, on 12 July staff were concerned that the man's mood had altered. The security department informed staff that, during a telephone call, he had told his partner he was going to hang himself. Due to his history of self-harm, the ACCT process was recommenced. The man told staff that his main issue was that he was unable to see his partner, but he did not feel the ACCT processes were necessary.
26. A further mental health assessment was carried out on 23 July. The man said that, although he sometimes experienced suicidal thoughts, he would not act on them. He was offered regular support by the mental health team. It was recommended that he be prescribed Mirtazapine, an anti-depressant medicine.
27. He remained on the ACCT until 24 August. During the later ACCT reviews, he consistently told staff that he was not contemplating harming himself. However, he continued to behave disruptively and was involved in fights with other prisoners. He was monitored and supported in accordance with the anti-bullying strategy as well as the ACCT process, as another prisoner had claimed that he had bullied him.
28. The man was reported to have told court officials on 30 August that he was feeling suicidal and wanted to harm himself, although he denied this when he returned to Glen Parva. It was written in his medical file that he had told staff that he only spoke about harming himself to prevent being remanded in custody. The investigator was unable to find out any further information about this incident.

29. The man was seen on a weekly basis by mental health nurses. On 5 September 2007, he was referred to a psychiatrist as he was feeling paranoid and struggling to cope with his temper. An appointment was due for 20 September but this was not kept as he was in court for sentencing. He was sentenced to six and a half years in prison.

HMYOI Swinfen Hall

30. On 3 October, the man was transferred to HMYOI Swinfen Hall where he stayed until July 2008. During his time at Swinfen Hall, he continued to have problems managing his anger and regularly had outbursts of violence that required him to be segregated from other prisoners.
31. All prisoners are seen by a nurse or doctor when they arrive at a new prison. The nurse who saw him when he arrived at Swinfen Hall referred him to a mental health nurse for an assessment.
32. The mental health nurse saw him on 7 October. She noted his history of drug abuse and previous attempts to harm himself. However, he did not appear to be depressed at the time and there was no evidence that he had any intention to deliberately harm himself.
33. Despite this, on 19 October officers asked a primary care nurse to see him as they were concerned about his state of mind. The nurse referred him to the mental health nurse for another review.
34. The following day, the man was disruptive in the visits hall at Swinfen Hall and, on 21 October, he told the mental health nurse that he had punched a window in frustration. He said he felt frustrated as he was having problems with his partner and was only able to see her in a room through windows because of problems in the past. (This type of visit is known as a closed visit.)
35. The mental health nurse noted that he appeared frustrated and agitated. She discussed anger management programmes but he said that he did not wish to be referred. She wrote that she would revisit this in the future.
36. The man's prescription was reviewed on 13 November. The Mirtazapine was discontinued and another anti-depressant, Citalopram, was prescribed. He was not happy with this change and repeatedly asked to be put back on Mirtazapine. He became more and more disruptive.
37. ACCT processes were started on 27 November as he was feeling low in mood due to his problems with his partner. The ACCT form was closed the next day as staff were convinced that, whatever problems he was experiencing, he did not intend to harm himself.

38. The man was housed in the Care and Separation Unit at Swinfen Hall during most of January 2008 because of his continued disruptive behaviour. However, he then seemed to settle into a more stable approach to life. On 4 March, a mental health review took place and it was noted that he was taking his anti-depressants and would like to attend the gym. The man said that he still found it difficult to control his temper, and the nurse noted that she would refer him to the gym and psychology department.
39. Within a fortnight, the man's disruptive behaviour had led to a further period in segregation and, on 23 March, he suggested that he would go on a hunger strike. He did not carry out this threat but attempted to hang himself on 25 March. Staff found him on his bed with a noose around his neck. He did not harm himself significantly and later said that he had done so because he was irritated by staff, and because he was only able to have closed visits with his partner. ACCT procedures were begun and he was placed in a camera cell in the segregation unit with a requirement for staff to observe him five times an hour. The mental health in-reach team saw him the following day. Although he was angry about the closed visits, he told staff that he did not intend to harm himself. Following several reviews, the ACCT processes ended on 15 April 2008.
40. Although the ACCT was closed, the man remained largely uncooperative and, apart from a two day period, remained in the segregation unit until 29 June 2008. He was downgraded to the basic level on the Incentives and Earned Privileges scheme, and staff used control and restraint methods on several occasions during this time. He was checked regularly by nurses but usually refused to see them.

HMYOI Brinsford

41. The man demanded a transfer to another prison while at Swinfen Hall because he claimed that no one liked him. He was transferred to HMYOI Brinsford on 5 July 2008 where he remained for six weeks.
42. A nurse saw him on 6 July to carry out the routine health screening for new prisoners and noted that no concerns were raised.
43. Prisons and young offenders institutions offer substance users Counselling, Assessment, Referral, Advice and Throughcare Services (CARATS). A CARATS worker saw the man on 11 July for an assessment. He asked for a place on an Enhanced Thinking Skills (ETS) course and to attend an Anger Control training course. It was noted that he had been waiting for a place on an ETS course at Swinfen Hall but had been transferred before one became available.
44. The man tied a ligature around his neck on 23 July and said that he "wanted to end it all". The nurse who attended to him noted that he

45. The man was re-classified as an adult prisoner on 12 August as he was approaching his 21st birthday. This meant that plans were put in place to transfer him from a young offenders institution to a prison. When given this news he was argumentative, mostly about personal belongings that he said had gone missing.
46. He continued to experience problems coping with his anger and frustration. The next day, a mental health nurse saw him as he had once again tied a ligature. He again said that he had not intended to take his own life but was angry because he had been unable to have a telephone call.
47. A prison doctor prescribed him 25mg of Quetiapine daily on 14 August and said that he would see him in one week to review his progress. Quetiapine is an anti-psychotic medicine licensed for the treatment of schizophrenia and the manic phases of bipolar disease. The man did not have either of these conditions but doctors may use their clinical judgement to prescribe medicines for use beyond their licence if they believe it to be in the interests of the patient. In the clinical review it is noted that, "Quetiapine is used at low doses for the management of agitation in the prison setting." However, he was transferred to HMP Hewell on 19 August, which meant that the review with the prison doctor did not take place. It also meant that the man had still not got onto an ETS course. I am unable to explain why this move took place.

HMP Hewell

48. The man was prescribed Quetiapine on arrival at Hewell on 19 August. The cell sharing risk assessment document made no reference to any self-harm issues and he was judged to be at medium risk to any cell-mate. He appeared to settle in well to his new environment although he continued to challenge authority.
49. A nurse saw him on 22 September because he was not taking his medicine regularly as prescribed. The man felt that the medication was not enough, and asked to be able to take it in the evening as the timing of the morning dose interfered with his education.

HMP Featherstone

50. The man was transferred again on 7 October, this time to HMP Featherstone. It is unclear why the decision was made to transfer him after such a short period at Hewell. He was located on House Five, the induction and reception unit at Featherstone. The cell sharing risk assessment has a reference on it to the man's previous self-harming and aggressive behaviour. He was assessed as being at medium risk to potential cellmates, but it was advised that he should not share a cell with a black prisoner or a prisoner from another minority ethnic background as he had expressed some racist opinions. An acquaintance to the man, described him as quite volatile when he first came to Featherstone and advised him to calm down.
51. An entry was made in the Public Protection Log at Featherstone on 13 October to alert the Safer Custody team to the man's history of suicide and attempts to harm himself. This information was passed on by email on 16 October. The Safer Custody team contacted the Senior Officer on his wing, who then interviewed him. No concerns were raised regarding the man harming himself.
52. A CARATS worker discussed the idea of the man doing a P-ASRO (Prisoners – Addressing Substance Related Offending) programme on 15 October. There is no record of a referral being made at this stage.
53. The man was found in possession of drugs on 19 October and was charged with an offence under the Prison Rules. My investigator was told that this charge was dismissed by the adjudicating governor. The investigator could not find any further information about this, and uncovered nothing to suggest that he was a regular drug user in prison.
54. The man had been referred to see the doctor during his reception healthscreen. The doctor did not see him until 22 October. The man asked for the dose of the Quetiapine to be increased. He said that it was working but he remained very agitated. It was agreed to increase the dose to 50mg daily and to review him again in two weeks. There was no note recording his history of self-harm or suicide attempts or his substance use.
55. It seems that the man was making attempts to address his behaviour and to conform to the prison regime. He was given feedback by staff on 24 October praising him for his efforts and that he had used the induction to Featherstone to good effect.
56. On the same day, he made a written complaint about not being allowed to have some photographs sent in by his partner. The photographs were stored in his property box. (The property box is held in reception, and is not in the possession of the prisoner.)

57. A few days later, on 28 October 2008, he was placed in a single cell due to his volatile behaviour and angry outbursts. He remained in House Five until 29 October when he was moved to cell 92, House Four, a normal residential unit. On 5 November, it was reported that he appeared to have settled in well.
58. He saw the doctor again on 10 November. He said that he could not sleep and was stressed. The doctor prescribed 50mg of Promethazine to be taken at night. (Promethazine is an anti-histamine drug that can be used as a sedative.) The doctor also decided to continue the Quetiapine at the higher dose.
59. On 13 November, the man made another formal complaint about a package he had yet to receive. On this occasion he had a reply on 14 November that advised him that a recorded letter had been received that day which contained four photographs, a letter and five stamped addressed envelopes.
60. It was reported by an officer on 16 November that he had been in possession of a mobile telephone but another prisoner had stolen it from his cell. The Security Information Report (SIR) that the officer completed recommended that a cell search of the suspect should be undertaken. The cell was searched but a mobile telephone was not found.
61. The doctor was due to review him on 19 November but the man failed to keep the appointment. A new appointment was made for 24 November but it appears that he did not attend this one either. This was not followed up by the healthcare staff, as there was no system in place to monitor patients who did not keep appointments.
62. An offender manager, reviewed the man's sentence plan on 26 November and noted that he needed to carry on with his good behaviour. He was referred to the Psychology Department for a place on the anger management course. Unfortunately, the last anger management course to be run at Featherstone in 2008 had just taken place on 18-20 November. In response to the draft report, the National Offender Management Service said: "This is a short duration non-accredited course which consists of eight sessions over four days. Programmes are not scheduled annually as they are delivered subject to facilitator availability in between accredited programmes."
63. The man was heard expressing racist views on 3 December, and the following day he was referred to the Safer Custody Team as he felt in danger from other prisoners after the loss of his mobile telephone. He reportedly told staff that he was having problems, but would not tell them anything substantive.
64. On 6 December staff became aware of intelligence that suggested the man had a 'shank' - a hand made sharp weapon – in his cell. A senior

65. Following his expressed fear of other prisoners and the discovery of the 'shank', the man was interviewed by a senior officer (the one that had previously searched his cell) on 9 December as part of the Safer Custody procedures. The man said that he was not feeling under as much threat as he had been a few days earlier. The senior officer noted that he was a quiet man who only told staff what he thought they should know. He was told about the support mechanisms available and encouraged to approach staff if he wanted help. When the investigator spoke to the senior officer about this conversation, he was unable to remember it. However, he did say that in his interactions with the man he viewed him to be a prisoner who posed more of a threat to others than to himself.
66. The man was awarded the 'Level 2 Award in Food Safety in Catering' on 15 December 2009.
67. On 21 December, he had a heated argument with another prisoner on House Four. He accused the other prisoner of stealing his mobile telephone. The SIR raised following this incident recommended that the other prisoner involved should be added to the cell search list.
68. The next day, the man was moved from the Care and Separation Unit to House 5, Cell 18, even though this House is primarily for the induction and reception of new prisoners. He did not share a cell. The man was noted to be agitated, saying that the prisoner with whom he had been arguing was making threatening and abusive telephone calls to his partner and his mother.
69. On 24 December, it was reported that the man was trying to find out from other prisoners what would happen if a prisoner was to barricade his cell. He also wanted to know if night staff carried keys. The SIR submitted on this matter suggested that he should be monitored, and spoken to by Senior Officer A. The investigator spoke to Senior Officer A. Senior Officer A who was unable to remember this conversation but said that this was the usual process followed at Featherstone. Senior Officer A also said that, in his view, the man was much more likely to be an aggressor than someone who might harm himself. He said that the man came across as in control and he was not concerned that he might harm himself.

70. On the same day a Governor replied to a complaint from the man regarding the confiscated photographs. The man was told that he should ask his partner to resend the photographs. Another SIR was raised regarding the issue of prisoners using the man's mobile telephone to contact his partner.
71. On 28 December, it was reported that another prisoner was continuing to make abusive telephone calls and send abusive text messages to the man's family and partner.
72. The following day, the man made a telephone call to his partner at 11.07am. It was a long conversation, which was monitored by Featherstone security staff. He and his partner argued about their relationship. However, they ended the call saying that they loved each other and he said that he would call back at about 6.00pm.
73. The man subsequently made over 20 further telephone calls. He telephoned friends and family trying to find his partner but did not manage to speak to her. On the final call, at 7.42pm, the man left an angry message on his partner's answerphone. He said that he believed she was having an affair, and that she had broken his heart.
74. At 8.15pm, Officer B began his night shift on House Five and checked on all of the prisoners. Later, at 00.15am, Officer B was doing his rounds when he heard music coming from the man's cell. When he looked through the flap he saw the man hanging from the light fitting. He immediately radioed for assistance, entered the cell and held the man up by his legs until Officer A arrived. Officer B said:
- "I remember thinking when I was lifting him up ... without fail 100% I knew he was dead I'm afraid."
75. Officer B cut the ligature and they laid the man on the bunk. There was no sign of life and he was cold to touch. He was also stiff as rigor mortis was beginning to affect the body. (Rigor mortis is the stiffening of the body after death because of a loss of Adenosine Triphosphate (ATP) from the body's muscles. ATP is the substance that allows energy to flow to the muscles and helps them work, and without this the muscles become stiff and inflexible. Rigor mortis begins throughout the body at the same time but the body's smaller muscles - such as those in the face, neck, arms and shoulders - are affected first. Rigor mortis normally appears within the body around two hours after death. However, it should be noted that the speed of rigor mortis is affected by a number of factors including the size of the person and the ambient temperature.)
76. A letter was found on the floor of the cell addressed to the man's partner. This explained that he felt heartbroken because he believed his partner to have been unfaithful.

77. Badger Harmoni, the out-of-hours provider for the PCT, was called. At 1.10am on 30 December, a doctor arrived and certified that the man was dead. In the early hours, a Family Liaison Officer was called and appointed the prisons Family Liaison Officer.
78. Early in the morning of 30 December, a Governor, accompanied by the Family Liaison Officer, visited the man's partner to inform her of his death. They initially visited an address but no-one was there. The prison had a phone number for the man's partner's stepfather who came and met the Governor, the Family Liaison Officer (FLO) and took them to another address. They broke the news to the man's partner and left their contact details.
79. The FLO also spoke to the man's mother. The FLO later returned the man's property to his partner. The man's mother had also sent some property in for him that arrived after his death. This was returned to her.
80. Following the man's death, staff overheard prisoners saying that two prisoners had caused trouble for him by contacting his partner. Another prisoner suggested to staff that the man was being 'hassled' by other prisoners.
81. Her Majesty's Coroner asked for a post mortem examination. Toxicology tests revealed no evidence of drugs or alcohol, and the cause of his death was determined to be hanging.

Support for the man's family

82. The FLO offered assistance to his partner and the Governor of Featherstone offered a financial contribution to the funeral expenses.
83. The man's partner has asked about the whereabouts of some photos she had sent in to him. The FLO explained that they had been destroyed as they were deemed to be inappropriate, and he was unsure who had sent them.

Support for staff and prisoners

84. Officer B was very complimentary of the support offered to him by a Senior Officer and Officer A immediately after the man was found. This support continued through the following nights, and I am pleased to acknowledge this in this report.
85. The care team was deployed to help any staff who felt affected by the man's death, and this support too was ongoing.
86. The Governor distributed a notice to inform prisoners of the man's passing. Staff personally told an acquaintance of the man about his death which he told the investigator that he had appreciated. He also

ISSUES

Clinical care

87. The clinical reviewer has looked into various areas of the man's care and I would encourage all of those responsible for prisoner healthcare at Featherstone to note the recommendations made. The clinical reviewer concludes that:

“... there is no evidence that the man's management of clinical care was inappropriate.”

88. However, the clinical reviewer criticises the standard of record keeping:

All medical records should be complete, accurate and signed and dated by the person making the entry. The entry and signature must be legible and made in line with good record keeping standards.

Medication

89. The man was prescribed Quetiapine to help him control his emotions and behaviour. The clinical reviewer notes that this medicine is licensed for the treatment of people with schizophrenia or manic phases of bipolar disorder. The clinical reviewer was told that Quetiapine can be used at low dosages for the management of agitation in a prison setting. In the clinical reviewer's opinion:

“... the choice of drug and dose appear to have been appropriate. The Head of Medicines Management's view was that whilst the use of this drug in this context is unlicensed, there is no suggestion that based on the clinical opinion of the GPs interviewed that this was anything other than appropriate, and the standard of care satisfactory in this respect ...”

90. The man failed to attend doctors' appointments in the last six weeks of his life. He did not collect his medicines after 6 December, and was not seen by healthcare from this date on (except if he was seen in the Care and Separation Unit on 22 December). The man was complimented for his recent good behaviour on 26 November and it may not have been a coincidence that, following 6 December, his behaviour went downhill again. While I cannot prove a connection, it is clearly disappointing that the man, with his known difficulties controlling his emotions, failed to collect his medication. It is true that in the community people have a choice whether to take their medication, and this choice was open to the man as well. However, given the vulnerability of so many prisoners, and the fact that the man himself was on mood-altering medication, it is very regrettable that his decision not to collect his medications was not followed up.

91. The Healthcare Manager, told the investigator that, at the time, there was no system to follow up patients who failed to attend appointments. The clinical review makes reference to a new policy introduced in January 2009 to flag any non-compliance with prescribed medication. The clinical reviewer has made a recommendation on this matter which I have adapted to read as follows:

The Head of Healthcare must ensure that a revised policy is fully implemented to alert staff when appointments are missed or drugs are not collected by prisoners on mood-altering medication.

Availability of courses

92. The clinical reviewer says that, although he underwent two mental health assessments, no mental illness was ever identified. However, it is clear from the account of the man's time in custody that he had great difficulty dealing with frustration and managing his anger. This led to repeated episodes of violence and self-harm. Courses such as Enhanced Thinking Skills and Anger Management are designed to help prisoners deal with these issues in a more controlled way. He might have benefited from participating in these courses. The man's partner has concerns that he was unable to access these courses.
93. The courses were discussed with him on a number of occasions and there is a note that he was on a waiting list at Swinfen Hall but was transferred before a place became available. It was not until 26 November 2008 at Featherstone that a referral is recorded, and by then no courses were available.
94. I have not considered whether there are a sufficient number of such courses, given the demand for places, but in the man's case his chances of finding a place were reduced as a result of the number of prison moves he experienced. In response to the draft report, NOMS said: "ETS courses run consistently throughout the year. Places on the programme are subject to national selection criteria, which means that access is based on a number of factors including risk and tariff expiry." (I may add that I am disappointed that a young prisoner was subject to so many moves in such a relatively short time, whatever the impact on his accessing offending behaviour programmes. The man's partner has also expressed her concerns with his frequent moves.)

95. Each prison noted the need for him to attend a course, but he was transferred before it ever came to fruition. Given that the prisons noted his need to attend the courses, I believe it would have been beneficial for this need to have been highlighted in his file before any transfer. The receiving prison would then have been aware of the need for him to attend the courses as soon as possible. This is a matter for NOMS centrally to consider:

Governors should be reminded that any urgent need to attend courses should be highlighted in the file of prisoners being transferred between prisons.

Suicide and self-harm monitoring procedures

96. The man was not subject to ACCT monitoring procedures at the time of his death. However, during his time in custody, staff had recognised the times when he had harmed himself or appeared to be at risk of doing so. ACCT monitoring procedures were begun five times before he went to Featherstone and it appears that his safety was taken seriously by prison staff. The man's partner was of the view that an ACCT should have been begun for him.
97. Annex 9P to PSO 2700 (Suicide and Self-Harm Management) states:
- “It is easy to think that only people who appear openly distressed or are quiet and withdrawn are at risk of hurting themselves. As a result, the risk associated with difficult, uncooperative individuals is commonly under-estimated and misunderstood. There is an association between disruptive, violent behaviour associated with ‘personality disorder’ and personal distress, mental disorder, drug/alcohol problems, self-harm and suicide. That is, people who behave ‘badly’ in ways that infringe discipline are more likely to be simultaneously in need to help and support than those who don't. Some individuals also provoke restraint situations and conflict with their peers as a way of self-injuring.”
98. While at Featherstone, the man was at times uncooperative and difficult. He had several volatile outbursts, was in conflict with other prisoners, and spent time in the Care and Separation Unit. Despite this, staff did not consider it necessary to instigate formal ACCT procedures. When he arrived at Featherstone, the Safer Custody Team was informed of his self-harming history and they ensured that wing staff interviewed him. This is encouraging to note, and represents an important way of attempting to safeguard prisoners. In the event, he denied any self-harm or suicidal ideation which explains why an ACCT was not begun.

99. Following the discovery of the 'shank' in early December 2008, the Safer Custody Team again ensured that the man was spoken to about any thoughts of harming himself. Once again he denied that he had any such intention. He was also spoken to on 24 December in response to another Security Information Report. On each occasion the staff member did not consider the man to be a risk to himself. Despite his history of self-harm and suicide attempts, I judge that Featherstone took their duty of care seriously. The Safer Custody Team intervened twice in response to documentary and empirical evidence that he might have been at risk. However, these interventions raised no concerns sufficient for ACCT procedures to be opened.

The harassment of the man by other prisoners

100. According to his acquaintance, the man was easily wound up, particularly with regard to his partner. He had illicitly acquired a mobile telephone while in prison. This was stolen by another prisoner which greatly agitated the man. It appears that he had used the mobile telephone to contact his partner and his subsequent inability to do so caused him distress. This was added to by other prisoners apparently using the mobile telephone to contact and abuse the man's partner. He was involved in a number of incidents with the prisoners he believed to be the perpetrators. His acquaintance said that he would get very wound up over any problem with his partner and "the whole wing would hear about it".
101. Prison staff filled out a number of SIRs regarding the man's loss of his mobile telephone and the effect this had on him. Cells of the suspected perpetrators were searched by staff but the device was not located. He was also moved in an attempt to separate him from the prisoners he was in conflict with. The Safer Custody Manager, told the investigator that such incidents were, at the time, deemed to be predominantly security concerns and dealt with as such. However, Safer Custody Manager explained that the situation had now changed at Featherstone. Given the capacity for the use of mobile phones to involve drugs, coercion and harassment, the Safer Custody Team is now informed of all SIRs of this nature. This change in policy is to be welcomed, and the experience at Featherstone could usefully be shared with other prisons.

The light fitting in the man's cell

102. Officer A told my investigator that two holes had been burned into the sides of the cell light fitting and that the ligature he used had been passed through these holes. The light fitting was made of a hard plastic that was able to withstand the man's body weight.

103. The light fitting was replaced after his death and the replacement was made of a lightweight plastic that would break if subjected to a heavy weight.
104. The man was not in a safer cell and was not deemed to be at risk of suicide at the time of his death. I understand that there were other places in his cell where a ligature could have been tied. For this reason, it would be disproportionate to recommend that all such light fittings are changed at Featherstone. However, I have investigated all too many deaths where the ligature was attached to a light fitting. Thought should be given to this when prisons are built or refurbished, and changes are made to any cell light fittings in the future.

I recommend that the National Offender Management Service ensures that, where new prisons are built or old ones refurbished, consideration be given to using a lightweight light fitting to minimise the chance of it being used as a ligature point.

The discovery of the Man

105. He was found by Officer B who immediately raised the alarm. The Night Orderly Officer, went to the cell with Officer A and found Officer B supporting him. The man was cut down and put on the bunk. The Night Orderly Officer told the investigator that the physical state of the man's body indicated that rigor mortis had set in and he was clearly dead. The Night Orderly Officer described the situation as "obviously hopeless". The same officer also commented that he had received first aid training and he performed the necessary checks before making this judgement. He described the man as cold and stiffening. He had also been incontinent. Annex 13A of PSO 2700 states:

"If not breathing and/ or no pulse is present, clear airway and attempt resuscitation, using a face mask with non-return valve, unless rigor mortis of the limbs has clearly set in." (Emphasis in original)

106. The clinical reviewer reports that:

"It is not standard practice, within prisons, for an ambulance to be called or resuscitation attempted where there was clear evidence that death had occurred some time earlier as appears the case here ..."

107. Given the checks undertaken, and the existence of rigor mortis, I accept that the man had passed away. In such circumstances, any attempt at resuscitation would have been worthless. Worse still, it would not have been respectful either to the staff asked to carry out CPR or to the man's memory. However, the tragedy of his death is an opportunity for the Governor to ensure that his staff are aware of the guidance if a prisoner is found in a life-threatening situation. I might

The Governor should ensure staff are aware of the requirements of PSO 2700 regarding actions following self-harm.

Issues concerning liaison with the man's family

Availability of family liaison officers

108. My investigator was told by the FLO that he was asked to be the family liaison officer despite not having had the formal family liaison officer training. The FLO said that he had experience of the role in his previous position at HMP Birmingham. Although such experience is useful, it is disappointing that Featherstone had to use a member of staff who had not had the recommended training. I understand that he is due to undertake the training in March 2010. I would encourage the Governor to ensure that he has a sufficient number of trained family liaison officers:

The Governor should ensure that he has a sufficient number of trained family liaison officers.

The man's property

109. He had made formal complaints about not receiving property that had been posted to him. In particular, he was upset because he was not allowed to have some photographs sent to him by his partner. These had been stored in his property box. These were later returned to his partner.
110. Following the man's death, a Family Liaison Officer was appointed by the prison. Part of his duties in this capacity was to return the man's property to his partner as his listed next-of-kin. When the FLO saw some photographs in the man's cell he deemed them inappropriate and arranged for them to be shredded.
111. When asked about this by my investigator, the FLO said he judged that it was in her best interest to destroy the photographs. The man's partner raised this with my own Family Liaison Officer and subsequently asked for them to be returned to her. The FLO's actions mean that the prison no longer has them and cannot fulfil this request.
112. I believe that the FLO acted in good faith but he would have been best advised to deal with the photographs in a more sensitive manner, recognising that they were not his to destroy. The Governor should ensure that there is no repetition, and may wish to write to the man's partner about this matter. The man's partner has also asked about the remainder of his property. Although I am not aware of the details of her

CONCLUSION

113. Although the man had engaged in many acts of self-harm during his time in custody, I do not think that his decision to take his life when he did could reasonably have been foreseen. At Featherstone, staff engaged with him and attempted to ensure that he was not harbouring thoughts of harming himself. He was clearly struggling with his emotions and personal relationships but I do not think staff could have anticipated the effect it would have on him.
114. Nevertheless, I think there are some important learning points from this tragedy. It is particularly disappointing that no-one followed up the fact he had stopped taking his medication. I have been pleased to learn that a new policy is in place to prevent this happening again. The inability of the man to access courses helpful to him is also a concern.
115. And I wonder about the extent to which anyone stood back and considered the man's situation as a whole. The man was a disturbed young man with a history of self-harming by ligature. He had spent a lot of time in segregation, and been transferred from jail to jail. He was concerned by the state of his relationship with his partner, and in conflict with other prisoners. He had stopped using mood-altering medication. These are all risk factors in prison suicides.

RECOMMENDATIONS

The National Offender Management Service had not responded fully to the recommendations at the time of the publication of this report.

1. All medical records should be complete, accurate and signed and dated by the person making the entry. The entry and signature must be legible and made in line with good record keeping standards.
2. The Head of Healthcare must ensure that a revised policy is fully implemented to alert staff when appointments are missed or drugs are not collected by prisoners on mood-altering medication.
3. Governors should be reminded that any urgent need to attend courses should be highlighted in the file of prisoners being transferred between prisons.
4. I recommend that the National Offender Management Service ensures that, where new prisons are built or old ones refurbished, consideration be given to using a lightweight light fitting to minimise the chance of it being used as a ligature point.
5. The Governor should ensure staff are aware of the requirements of PSO 2700 regarding actions following self-harm.
6. The Governor should ensure that he has a sufficient number of trained family liaison officers.