

**Investigation into the circumstances surrounding the  
death of a man at HMP High Down  
on 11 December 2007**

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

**January 2009**

This is the report of an investigation into the death of a man, a remand prisoner who was found hanging in his cell at HMP High Down on 11 December 2007. The man was 20 years old. He had been at High Down since 31 October and was awaiting trial for murder.

I offer my sympathies to the man's family, friends and all those affected by his loss.

The investigation was conducted by two of my investigators. A clinical review into the care received by the man while he was in prison was undertaken by an Independent Health Clinician for the Surrey Primary Care Trust (PCT). A psychiatric report, written by a doctor in psychiatry, was also commissioned by the PCT to assist with this investigation. Although these reports were somewhat delayed, I am most grateful to the health clinician for the Surrey PCT and the psychiatrist doctor for conducting their respective reviews. I am also grateful to the Governor and staff of High Down, especially the Governor for her assistance and co-operation during the investigation process.

The man had had previous contact with mental health services. There had been periods in his short life when he experienced depression and paranoia, and he had abused alcohol. He also had a history of harming himself and had notably done so only two days before being taken into prison custody. When he arrived at High Down, an ACCT document was opened and the man was admitted into the healthcare in-patients unit immediately. He was subsequently transferred to a wing, but his mood remained low and he reported hearing voices. He continued to express a desire to take his own life, and his eating pattern was very disturbed, although he made no actual attempts at self harm or suicide until the morning of his death.

I conclude that the man received a generally good level of individual care and support at High Down, and I commend staff for their attempts to improve the man's outlook on life. I also make nine recommendations, primarily covering healthcare processes, self harm monitoring procedures and family liaison. I note that following the man's death, the prison healthcare in-patient unit carried out a review of its procedures. I hope the findings of my report, along with their own review, will be acted upon swiftly to improve the level of care given to prisoners in healthcare.

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

**January 2009**

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## **SUMMARY**

The man arrived at HMP High Down on 31 October 2007, having been remanded in custody awaiting trial for murder. He had previously served custodial sentences in three other establishments. His longest period in custody had been at HMP&YOI Reading.

Upon his arrival at High Down, it was noticed that the man was very withdrawn and isolated. When examined by the healthcare staff in reception, he admitted that he had harmed himself only two days earlier. Scars on his forearms confirmed this. The man was immediately transferred to the in-patient healthcare unit, where an Assessment, Care in Custody and Teamwork (ACCT) document was opened to ensure he was monitored and supported against self-harm. He was placed under constant observation.

The man remained in the healthcare unit for approximately three weeks, during which time the observations were reduced to once an hour. He received a great deal of support and care from healthcare staff whilst on the unit including regular assessments by the nursing staff and psychiatrist. However, his mood remained low, his interaction with others was minimal, and he regularly told staff that he intended to take his own life.

When the man was relocated to a residential wing, his ACCT remained open and wing staff continued to monitor him. It was hoped that having more access to facilities such as education would help improve his mood and interaction with others. However, he showed little improvement. The man did attend a music club and was later allowed to have a guitar in his cell, which appeared to help. However, his verbal expressions of a desire to take his own life continued.

Throughout the day on 10 December 2007, and leading into the early hours of the morning on 11 December, the man was checked by the staff on duty. He gave no particular cause for concern to any of the staff (including the night Officer Support Grade (OSG), who had a brief conversation with him before the man appeared to go to bed). He was then checked at regular intervals.

When the man was checked at around 4.15am by the OSG, he appeared to be standing up at the back of his cell. The OSG turned the cell light on and saw the man hanging from his wardrobe. He raised the alarm, and staff attempted resuscitation. A first response paramedic attended the prison, quickly followed by an ambulance crew.

Although the man had not responded to the attempts at resuscitation, the paramedics believed that, because of his young age, there was still a possibility that he might survive. He was taken to hospital where resuscitation efforts continued. However, soon after arriving, the doctors declared the man's death.

After the man was taken to the hospital, staff found letters and correspondence in his cell. He left information for friends and family which

explained that he had intended to take his own life. My report includes nine recommendations and two examples of good practice.

## THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened by one of my investigators on 19 December 2007 when he visited HMP High Down. He met the Governor and some of his staff. Notices of the investigation and terms of reference had already been sent to the prison; these invited anyone with any information to contact my investigators. No prisoners came forward to be interviewed.
2. My investigator also met representatives of the Prison Officers' Association and the Head of Healthcare. He visited the in-patient unit and house block 1, where the man had lived, and met a representative of the Independent Monitoring Board. My investigator returned later to conduct interviews, accompanied by my second investigator.
3. A clinical review was commissioned from Surrey PCT to assess the man's medical care. This also included a psychiatric review. I am grateful to the health clinician and to the psychiatrist for their respective reports.
4. One of my Family Liaison Officers (FLOs) made contact with the man's mother and father, informing them of my investigation. The following issues were raised in relation to their son's death, and I hope I have addressed them fully in my report:
  - The man's family believe that he was clearly unwell when he went into prison. He was very depressed, would not talk to anyone and would not make any eye contact. They noticed this on their visits to see him in prison. The prison had identified this and put him on 15 minute observations. The man's mother believes that these observations were reduced. At the time of the man's death he had not been checked for one hour and 20 minutes.
  - The family also believe the man may have deliberately negotiated his way off the healthcare unit, knowing that he would not be observed as frequently by wing staff.
  - The man's mother explained the difficulty she has had contacting the prison FLO on the number that was provided. She was aware that the FLO had a period of annual leave but was concerned that they had waited a long time for the man's belongings to be returned.
  - The man's mother said that the way in which the prison handled the matter of the funeral costs had caused the family distress. The prison did not offer any assistance at first. Only when the man's mother broached the subject did the prison offer financial assistance up to £2,000. The man's mother had received quotes for the cost of the funeral, the cheapest of which was £3,279. She therefore spoke to the prison again to request assistance to cover this amount and was informed that the Governor would consider it. The man's mother said

that the prison eventually agreed to meet the full funeral costs, but that they had taken a week to make this decision. During this time, she was very distressed as the family could not move the man's body or hold his funeral.

5. The man's family read our report and shared a number of the concerns raised in my investigation. Although these do not lead to factual changes the report, I am grateful for them sharing their views with us. In particular the man's father had concerns that the man was treated as an adult in an adult system despite having a much younger mental age. He feels that if the prison service had involved the man's parents in his care they could have learned more about his issues and hence been better able to meet his needs. He feels strongly that self-reporting was not reliable and additional information could have been sought.

## **HMP HIGH DOWN**

6. HMP High Down opened in September 1992. It was initially a core local prison (able to take top security category A prisoners) but in 2003 it became a category B prison. It routinely holds approximately 750 prisoners. Each house block has three spurs (A, B and C) and each spur is broken down into three levels, 1 being the lower level, 2 the middle and 3 the upper level. There is a gate at the end of each spur.
7. House block 5 opened on 26 November 2007, which was followed by house block 6 in 2008. With the introduction of the new house blocks, the prison now holds 1103 prisoners. As part of the building work, a new education block has been added, which is now open. There is also work in progress to improve the kitchen and the reception area. High Down's regime includes education, catering, workshops and painting and decorating courses.
8. The healthcare centre has 23 in-patient beds, all in single cells, supported by 24-hour nursing cover. A range of primary care services is also available for prisoners. Four of the healthcare cells have gates rather than doors to allow staff to observe the patients in those cells more closely. There is a day area where the patients can watch television and relax. Twice a week, a member of the education staff attends the day centre and provides activities for the men.

## **Independent Monitoring Board (IMB) report**

9. IMB members are appointed to each prison by the Secretary of State for Justice. They are not members of the Prison Service, nor are they part of the prison's management team. They are required to report annually to the Secretary of State, highlighting good practice and any areas of concern.
10. The IMB's report for High Down for the period 2006-07 emphasised the increasing range and mix of prisoners in the establishment, some of whom they believed were inappropriately placed in a local prison. They also commented on the difficulties caused by reduced funding and overcrowding. Despite this, however, they believed that High Down was well run, with "the vast majority of staff committed to providing a secure, fair and decent regime for prisoners". There had been particular emphasis in building good relationships between staff and prisoners.
11. In the section headed "Safer Custody", the IMB commented specifically on the delivery of the ACCT process. Although the system was well established and used, the quality of certain ACCT observations was described as "variable". However, the Board emphasised that this and other matters involving safer custody were being addressed in a co-ordinated and focussed way.

## **Her Majesty's Chief Inspector of Prisons' report**

12. The most recent inspection of High Down by Her Majesty's Chief Inspector of Prisons was an announced inspection in May 2006. Her report of her findings included the following:

“High Down, along with all local prisons, is under tremendous pressure as a result of the growth in the prison population. Despite this, the establishment had made considerable strides in a number of areas.

“Healthcare services were good in all areas except dentistry, and action to change the dentistry provider had begun. Primary care and GP clinics were delivered on the wings, and nurses were based there throughout the working day. An impressive array of visiting professionals supported these core staff. Mental health services were very good, with a coordinated strategy aimed at providing the best care either in the inpatients' facility or on the wings. The joint working between the in-reach team and the primary mental health team was particularly impressive. Prisoners residing in the inpatients unit were appropriately occupied in a day-care centre.

“There was a good suicide prevention policy document in place. Monitoring entries in ACCTs were generally good, although case reviews were poorly attended and the timing of some night entries was too predictable.”

13. Her Majesty's Chief Inspector recommended that checks by night staff on prisoners subject to open ACCT documents be frequent and unpredictable, and that case reviews should be attended by representatives of all departments that have regular dealings with the prisoner.

## **Previous PPO investigations into self-inflicted deaths at High Down**

14. There had been three previous apparently self-inflicted deaths in High Down, before that of the man, since my office took responsibility for investigating all deaths in prison custody in 2004. None of the recommendations made in the first two reports are relevant to this investigation.
15. The third death occurred in May 2007. My investigator made eight recommendations, of which two relate to the provision of mental health services at High Down, and three to the ACCT monitoring process. However, my findings were not shared in full with the Prison Service until January 2008

### **Assessment, Care in Custody and Teamwork (ACCT)**

16. ACCT has been introduced at all prisons as a documented process to monitor and support prisoners assessed as at risk of suicide or self harm. (The previous system was known as the F2052SH procedure.) Once placed on ACCT, the prisoner is observed at intervals determined by their perceived level of risk and observations continuing during the day and the night.
17. Each prisoner is assessed within 24 hours and then reviewed further at intervals decided on an individual basis. The ACCT guidance says that, to be effective, the review should involve the people who know the person at risk or are involved in their care.
18. Amongst other things, the ACCT guidance states that prisoners should be cared for in a safe environment. It is for the case review team to decide the most appropriate place to locate an individual prisoner.

### **Canteen**

19. Prisoners can obtain various foodstuffs and other items from the prison shop. (This is known as canteen.) They also have access to kettles and are provided with a weekly tea pack, bread and other food items. Prisoners use money from their prison cash account to purchase canteen items.

### **Cell Sharing Risk Assessment (CSRA)**

20. In order to make sure that unsuitable prisoners do not share cells (for example, a racist prisoner and one from a visible ethnic minority), a cell sharing risk assessment form is completed by reception staff when a prisoner first arrives at the prison.

### **Counselling, Assessment, Referral, Advice and Throughcare (CARATS)**

21. Organisations specialising in the treatment of substance abuse have drugs workers based in most prisons. CARATS workers can run programmes, offer counselling and support, and arrange referral on release. Access to CARATS is voluntary.

### **Induction**

22. Having gone through the prison reception process, prisoners at High Down are generally located onto the induction wing where facilities and the regime of the prison are explained. After a suitable period on the induction wing, they are re-allocated to a regular residential wing.

### **Peer advisors and Listeners**

23. In common with most prisons, High Down uses experienced prisoners to operate as peer advisors and Listeners. Peer advisors welcome new prisoners, highlight any concerns and explain the processes the newcomers will encounter in the early days of custody. Listeners assist those prisoners who require additional support at any time in their period in custody. (They are provided with training from the Samaritans to support them in this role.) Confidentiality is a critical feature of the Listeners' role.

### **Mental Health In-Reach**

24. The In-Reach team offers a mental health service for all prisoners who have enduring mental illnesses. They also treat and support prisoners who have mental health problems, offering intervention in crisis situations. The team supports prisoners who are on ACCT documents, and attend most ACCT review meetings.

### **Personal officer**

25. Every prisoner is assigned a personal officer. Their role is to meet on a regular basis and to discuss any issues or concerns the prisoner may have. High down operates a risk based personal officer scheme, which targets the more vulnerable prisoners as well as those with offending behaviour needs that mean they would benefit from this service. Any prisoner can request a personal officer, if they feel that it would help them.

### **Reception**

26. On arrival at HMP High Down, all paperwork is checked before prisoners are taken off the escort vehicle. Staff check warrants to ensure they have the correct prisoners in custody, and then set up the necessary records. The prisoner is taken from the vehicle and booked in by the senior officer on the front reception desk. Details of the prisoner and their offence are taken, together with any known or identified concerns.
27. All prisoners see the first night in prison officer, reception officers and the nurse on duty. During this process, staff obtain address and next of kin details. Prisoners are full searched, their property is logged, and they are health screened, before being placed in a holding cell ready for locating staff to take them to a wing.

### **Roll check**

28. The roll check is the physical count of the number of prisoners on each wing within a prison. Roll checks occur on a number of specified occasions during the day and night, and staff must sign that the roll is correct

## **Sealed key pouch**

29. The High Down night order instruction describes the sealed key pouch as follows:

“Sealed key pouches containing a cell key are distributed to all night staff patrolling units holding prisoners. They are to be used to gain entry into cells at night in an emergency in order to attend to a prisoner whose life is in danger.

“On discovering a life threatening incident, staff must raise the alarm by contacting the Control Room. The night patrol officer must decide whether aid is required immediately, or whether any delay may result in a very serious harm or death. If the latter is the case, the officer should break open the sealed pouch and use the key to open and enter the cell. If the life threatening situation is a self harm incident involving a ligature, the cut down scissors must be used whenever possible.”

## **KEY FINDINGS**

### **The man's previous prison sentence**

30. The man served a ten week custodial sentence at HMP&YOI Reading from 27 October 2006. On his arrival, a risk assessment was completed which noted that the previous day he had tried to find arteries on his arms and cut them with a razor blade. He had also previously made violent attempts to self harm and was currently experiencing suicidal thoughts and anxiety.
31. He was assessed by a psychologist on 27 October and 7 November 2006. The man said he was not sleeping well, had little appetite for food and experienced low concentration levels. He said he had made five previous attempts at self harm and had a suicide plan.
32. During the psychologist's assessment, the man avoided eye contact and spoke in a quiet and monotonous tone. His speech was fluent and there was no evidence of thought disorder. He was subsequently diagnosed as suffering from a reactive depression with anxiety, but showed no clear evidence of psychosis.
33. An ACCT document was opened and the man said that he would ask for help if he had any further thoughts of self harm. He was also prescribed sufficient sleeping medication for one week. A further appointment was made for him to be assessed again by the psychologist on 10 November. The man declined to attend the planned session, preferring to play the piano in the prison chapel. He was released from Reading soon afterwards.

### **Arrest and charge**

34. The man was arrested and charged with murder on 30 October 2007. He remained in police custody overnight, where he was subject to a constant suicide watch after admitting that he had recently self-harmed. The following morning, the man was placed into the custody of the escort contractor, Reliance Custodial Services (RCS), to be escorted to Portsmouth Magistrates' Court for his hearing.
35. The man arrived at court at 10.25am. The police had completed the PER (Prisoner Escort Record) Part B escort record and handed it to the RCS staff. It was noted that the man had been identified as being at high risk of self harm, was violent and possibly had a mental condition. He remained at court for the entire day and was checked at regularly intervals by the RCS staff. Throughout the day, it was noted that the man was quiet and did not eat the meals that were provided. It was also noted that there was evidence of recent cutting and self harm as he had marks on his arms. The man was later remanded into the custody of High Down.

## **The man's arrival at HMP High Down**

36. The man arrived at High Down at 5.35pm on 31 October and went through the normal prison reception screening process. He was quiet throughout and failed to make eye contact with staff whilst they conducted their assessments of him. It was noted that he had been charged with murder and that he was at risk of self harm. The man's cell sharing risk assessment (CSRA) document noted that he should be placed in a single cell because of the risk he might pose to others.
37. The Senior Staff Nurse was on duty in reception when the man arrived and interviewed the man as part of the reception screening process. The Nurse told my investigators that, as well as working in the prison, he is a Registered Mental Health Nurse (RMN) working as a psychiatric nurse in the community.
38. The Nurse said that, during the examination, the man said he had self harmed only days before being received into custody. It was a serious act of self harm, although he said he had no intention of taking his life. He also said he had a history of overdosing. The Nurse described the man's mood as "extremely low" and said he made no eye contact. Given the seriousness of the man's self harm attempt, the Nurse decided to open an ACCT document. He considered that the man was at high risk of self harm and felt that he should be admitted into the healthcare in-patients unit for further observation. The ACCT and CSRA document were noted to this effect.
39. The man was later transferred from reception to the healthcare unit at 6.50pm. He was interviewed by two Registered General Nurses (RGNs) on his arrival. They confirmed that the man had no medication in his possession and offered him the use of a telephone and access to the Listener service. His mood was again noted as being "extremely low". He remained withdrawn, made no eye contact and exhibited very low self esteem. The man said that he had not eaten or had a drink for two days. He was placed in a gated cell on level one observation (constant watch), with a full assessment scheduled for the following day.
40. In interview with my investigators the healthcare in-patient manager, said that when the man arrived in the healthcare unit the staff were concerned about him because he seemed "depressed and isolative". The unit had a psychiatrist who attended the prison twice a week, and the in-patient manager ensured that a referral was made for the man to be assessed.
41. Throughout the man's first night, the duty healthcare assistant observed and engaged in conversation with him. At around 11.00pm, the man had some tea and toast. Later he talked about his home life and friends. The following morning, the man spoke for an hour with the healthcare assistant. He talked about his offence and what had happened. The

man said he had no intention of self harming until after the verdict in his case. Should he be found guilty, he said he would kill himself in prison.

42. The man gave a number of reasons why he would kill himself and said that his life would not be worth living. The healthcare assistant continued to engage in conversation with him, offered him support and encouraged the man not to take his life.
43. The man's mood was still low the following morning (1 November 2007). His interaction with staff was minimal and he remained in his cell watching television. An ACCT assessment interview was conducted by an RGN at 11.25am. The man told the nurse that he had had a difficult childhood and had self harmed for a number of years, the last time being only two days ago. He admitted "there is a presence who makes him commit acts of self harm" and tells him, "not to eat or drink". He did not wish to socialise with others, preferring to be alone. The man said he would self harm, although he did not know exactly when and this was dependent on the "voice or presence". He added that he could not serve a long term sentence and would "end it all". The man had given the nurse permission to obtain his medical details from HMP&YOI Reading and she contacted them accordingly.
44. Immediately following the man's ACCT assessment interview, an ACCT review was conducted. The in-patient manager, an RGN and the man himself were present. The review concurred with the Registered General Nurse's assessment. An urgent referral to the prison psychiatrist was made for the following morning.
45. Details from the man's inmate medical record (IMR) were received by fax from Reading. They gave information relating to the man's mental health both before and whilst he was in Reading's custody. He had been placed on an ACCT document and had had contact both with a psychiatrist and a psychologist. The man had also complained of hearing voices whilst in his cell and it was noted that he was becoming paranoid.
46. As the day progressed, the man appeared more settled. He ate his lunch and dinner. In the evening, his behaviour was described by healthcare staff as "isolative and monosyllabic". He remained on level one observation.
47. From 2 November onwards, the man's behaviour showed little change. He made no attempt to harm himself but his interaction with staff remained minimal. His observation level was reduced from level one to level two (regular observations). It was noted in the man's ACCT document that on the evening of 3 November he remained quiet and withdrawn. He refused his evening meal but said he was okay and had no thoughts of self harm.

48. On 4 November, he was assessed by another registered general nurse. The man said he felt uncomfortable with adults as he had had a difficult childhood and, although he did not want to kill himself, he felt no emotion.
49. On 5 November, healthcare staff noted in the man's IMR that he was not eating. The man said he was not hungry and had already eaten an apple and had a drink. The In-Patient Manager told my investigators that the in-patient unit was a supportive and trusting environment. Staff believed that the man was not eating because he was depressed, and they were trying gradually and gently to encourage him to eat. The In-Patient Manager asked all staff to monitor the man's food and fluid intake.
50. The psychiatrist conducted an assessment. The man made poor eye contact and appeared depressed, but was able to smile on a few occasions and said he had no thoughts to harm himself. The psychiatrist wrote that the man should remain in the healthcare unit for further assessment. Later that evening (5 November), the man's mood was still noted as quiet. He spoke to a member of staff and said that since he had been in prison he had had no contact with anyone from outside. With his permission, the man's mother was telephoned and told that the man would welcome a visit from her. His eye contact and engagement with staff was a little improved and he repeated that he had no current thoughts of harm. That night it was reported that the man slept well.
51. The man remained on level two observations. He refused food at times and stayed in his cell a lot of the time. Staff continued to try to engage him in conversation but generally the man's mood remained low. He was given the opportunity to attend education classes and association with other prisoners to try to get him to leave his cell but he refused, opting to watch his television.
52. The man's second ACCT review took place on 7 November. The In-Patient Manager, an Officer and the man were all in attendance. The In-Patient Manager noted that the man remained withdrawn and was unwilling to socialise or speak with others. The man said he was still hearing voices. The offer of support continued and he remained on level two observations.
53. On the morning of 9 November, the man was escorted to court for a hearing. After this, for reasons not clear from his prison records, the man was initially taken to Reading and then back to High Down. On his return to High Down that afternoon, he was assessed by an RMN. The man made no eye contact and was unresponsive to her questions. He admitted hearing voices of unseen people commanding him to kill himself. He also admitted to having suicidal thoughts all the time. He had not been prescribed any medication. It was noted that a ligature had been found in the man's property when it was searched at Reading. An RMN Nurse said that the man's mood was low and he was considered to

be a risk of self harm. His ACCT document remained open and he was again placed on constant watch.

54. The following day, during a routine ward round, the man was seen again by the psychiatrist. On this occasion, the man said his aim was to be dead by the age of 21. The psychiatrist noted that it was possible that the man was suffering from a personality disorder. She recommended a referral to the prison doctor for the following week as well as out-patient follow up by herself.
55. Around lunch time on 10 November, a further ACCT interview was conducted. It was noted that the man had a history of self harm, had complained of command hallucinations, and had described experiencing intermittent paranoia. The man was "isolative", his speech was quiet and his eye contact was elusive. The man also did not appear to comprehend the seriousness of what he had been charged with. The man said he had previously had contact with mental health services. A referral back to the psychiatrist was noted on his records. Although it was not recorded at this review, it appears that the man's level of conversation and observation was level 2.
56. On 11 November, an Officer noted that the man refused breakfast and did not come out of his cell. He managed to get the man out of his cell in the afternoon, and took him to a private office in an attempt to engage him in conversation. They spoke for about 20 minutes. The man was not very forthcoming and said again that his goal in life was "to be dead" before he was 21. He claimed he had previously attempted to take his life but failed. The Officer noted that he had already contacted the man's mother to enquire about his behaviour. She had confirmed that the man had at times acted strangely and would sit in his bedroom for hours upon end. When the Officer ended their meeting, thanked him. The Officer then passed this information on to the nurse on the unit.
57. The following morning, no concerns were raised about the man. He had a visit in the afternoon and afterwards seemed calm and settled. Staff noted that he was quite chatty.
58. A Registered General Nurse spoke with the man on 13 November. He was still quiet and was not socialising much with others. However, he did speak with her and his eye contact was good throughout their conversation. He told the nurse that he had no current thoughts of self harm.
59. At the ACCT review on 14 November, the man was still low in mood. He said that he was having regular thoughts about the abuse he had suffered in the past. He reiterated his intention to kill himself but said he had no way of doing it. His ACCT document remained open and his monitoring continued.

60. Despite the man's isolation, staff thought that he appeared calm and more settled. On 15 November, the level 2 observations were discontinued after an ACCT review. Thereafter, the man occasionally joined other prisoners for association. No self harm concerns were noted. However, a Senior Officer (SO) carried out a further cell sharing risk assessment (CSRA) and noted that the man believed his situation was "hopeless". The man expressed not only a desire to die but also to harm others. He was to be assessed by the mental health team and encouraged to interact with others on the wing.
61. An entry by the psychiatrist in the man's IMR on 19 November showed that he missed his appointment because he was having a visit. However, the general feedback from staff was that he was more stable and there was no evidence of increased threats to harm himself. A plan was made to transfer the man to a single cell in a house block. He was to receive out-patient follow up care from the psychiatrist. Over the next couple of days, the man's behaviour was settled and no cause for concern was reported.
62. On 21 November, the man was assessed by the Mental Health In-Reach team and the SO noted that:

"After assessment it appears the behaviour he displays is his normal behaviour outside and although very introverted and quiet there is no evidence of mental health issues."
63. The SO carried out a further CSRA on 21 November. The man's risk level remained high and it was noted that he did not like being in prison nor in the in-patient unit. In respect of his mental health needs, the man was to be seen as an out-patient in the psychiatrist Doctor's clinic and was encouraged to interact with others on the wing.
64. As well as the man and In-Patient Manager, two other members of staff attended the ACCT review on 21 November. This was expected to be his last review before he was discharged from the healthcare unit. The man still maintained his intention to harm himself and end his life. He said he would take his life whether he was located in the healthcare unit or not and was just waiting for the "opportunity to do it". Despite staff encouragement to get him to interact with other prisoners and staff, the man told the review members that he had no future.
65. The In-Patient Manager told my investigators that there was no operational pressure to discharge the man from the healthcare unit. As time passed, and following discussions with staff at ward rounds, they felt that his quiet and introverted behaviour was part of his normal personality.
66. The man's ACCT entries show an intermittent pattern of engagement and isolation from everyone. The entries suggest that he was gradually more settled towards the end of his stay in the healthcare in-patient unit.

67. At the ACCT review on Friday 23 November, the In-Patient Manager broached with the man the possibility of relocating to a residential wing. The man had refused a request two days earlier, but on this occasion he had no objection and said he no longer had any thoughts of self harm. The In-Patient Manager said the man would be followed up by the In-Reach team and psychiatrist after he left the healthcare unit.
68. The In-Patient Manager noted that the man should remain in a single cell as the risk to others was greater than to himself. He discussed the proposal with other staff, including nurses, the in-patient team and the psychiatrist. The In-Patient Manager completed a discharge plan to be given to the staff on house block one stating that the man had a personality disorder, was low in mood, was not receiving any medication, and was being monitored by an ACCT document.
69. At interview with my investigators, the Mental Health In-Reach Manager, said that the man had not been formally referred at any time to the In-Reach team. Nor was he being supported by the In-Reach team, although he was assessed in the healthcare unit by the psychiatrist who was affiliated to the team.
70. Later in the evening of 23 November, the man was moved to house block one. An ACCT review was held at 7.35pm, attended by another SO, an Officer and the man himself. The man was quiet and gave one word responses to questions from the SO, his new case manager. He also ate no food that evening.
71. At interview with my investigating officers, the SO said that she was very concerned with the man's demeanour. He said he had no plans of self harming but was in shock at his predicament. He again mentioned hearing voices and wanted to play the piano which was located in the chapel. This request had previously been declined as he was in the healthcare unit. The SO said she would look into the man's request. The man added that he had no wish to attend work or education.
72. The SO told my investigators that, because of her concern about the man, and because she did not know him well, she increased the observations to hourly overnight. She was also aware that he would be in a single cell. Following the ACCT review she contacted the healthcare unit to see what further information she could gain about the man. The similarities in the man's behaviour in healthcare and the house block were confirmed by staff in both units.
73. The man refused breakfast and lunch on Saturday 24 November but, although not very communicative, he did collect his evening meal. On Sunday morning, he again declined breakfast and lunch and said he was happy to sit in his cell watching television. He collected his evening meal but refused to come out of his cell for association. A Nurse was

informed of the man's behaviour and made a referral to the In-Reach team.

74. A nurse from the In-Reach team saw the man on Monday 26 November. His conversation was very limited, although he said that he had no suicidal or self harm thoughts. The man was advised about the various coping mechanisms he could use. He was thereafter to be monitored by the house block nurse.
75. In general, staff found it difficult to have any communication with the man who invariably answered with one word answers. Principal Officer (PO) who was on duty on 27 November, attempted to have a conversation with the man and managed to "get a couple of giggles". The man told him that he was concerned about mixing with other prisoners as he was from a middle class background and would not fit in. The PO asked whether he felt like harming himself, but the man did not answer. He did say, however, that he would not "do anything" that night. An arrangement was made for the man to see a Listener to try and persuade him to associate more with the other prisoners.
76. On 28 November, another Officer had a long chat with the man about how he was finding prison life. He again said he felt he did not fit in because of his background. He had received letters and money from his parents, but did not want to speak to them on the telephone. The man also said that he was waiting to hear from his solicitor. The Listeners and Samaritans schemes were explained once more, and the man was reminded that he could talk to staff at any time about any worries. He told the Officer that he had pronounced thoughts of self harm and agreed he would make an effort to come out of his cell when she was next on duty (which was to be Saturday 1 December).
77. At interview with my investigators, the Officer said that the man appeared very "withdrawn and lost". She described him as someone who made minimal eye contact and gave one word responses when spoken to. He also rarely came out of his cell. The Officer said there were occasions when she repeatedly had to ask the man to come out to collect his meals.
78. A Principal Officer took the initiative to contact the man's solicitor on his behalf as he believed this would help the man. The solicitor confirmed that she had received the man's letter and planned to make a legal visit on 13 December. It was noted the next day that the man was making friends on the wing and asked if he could speak to two other prisoners in their cell. This was agreed to. Staff also told the man he would be able to join the music club in the chapel.
79. On 30 November, the man attended the chapel to play in the music club. He spent an hour and half playing the piano and guitar. He also had a visit from his parents. Later that evening, an SO held an ACCT review meeting with the man which lasted about one hour. No other staff

attended. The SO recorded that the man was a lot more talkative and maintained better eye contact during their conversation. He said that he had enjoyed the music club that morning. He told the SO that he had his own guitar at home and asked if it was possible for it to be brought in for him. He also asked if the education department could provide him with drawing and art materials to use in his cell. (A few days later the man was provided with an art set for his drawing and he said he would consider attending art classes in the education unit.)

80. When asked about his intention to self harm, the man told the SO that he had originally planned to kill himself on his 21<sup>st</sup> birthday (11 June 2008). He said that, because he was in prison, this was no longer possible. Nevertheless, he felt that he could not cope with a long sentence. The man said he still experienced thoughts of self harm and, although he had no set plan or timescale, said he still intended on taking his life.
81. On 1 December, the man again declined all meals and association. Staff found it difficult to engage him in conversation. An Officer tried to convince him to eat but the man said that he was not hungry. The next day, he again refused his breakfast and lunch but collected his evening meal.
82. At around 3.00pm on 6 December, staff allowed the man to telephone his mother to tell her she would be allowed to bring his guitar into the prison on her next visit. Following this conversation with his mother, the man spoke to the officer on duty and said he was okay and was “just getting used to the place”. He also said he felt that the “staff were smothering him”. Later that evening, although the man collected his evening meal, he remained in his cell.
83. The man’s next ACCT review was on 7 December, again conducted by an SO. The man initially was quiet, made no eye contact and gave closed responses to questions asked. However, his mother was bringing in his guitar the following day and he said he was looking forward to this. He was now occupying some of his time in his cell drawing. In respect of his self harming, the man said there was no change in how he felt.
84. Another SO also spoke with the man about his comment that staff were smothering him. The man said he did not feel uncomfortable and accepted that staff had to check on his wellbeing. He maintained that he had suicidal thoughts, although the SO felt that he seemed less specific about them than he had done in the past. The man did not collect his evening meal, saying he was not hungry. The SO gave him a packet of biscuits to eat in his cell.
85. The man again failed to collect his breakfast the following morning (Saturday 8 December), and did not leave his cell. When the man was checked, staff recorded that he was subdued and made no conversation. He was encouraged to eat and staff made a note to keep an eye on him. At lunchtime, and having seen the man emerge from his cell, staff again

checked upon him. He was sleepy and said he was not interested in lunch. Later in the afternoon, the man had a visit from his family. Staff spoke to him on his return and noted that his mood was much better.

86. On 9 December, the man received his guitar. Again he did not eat lunch or his evening meal, but remained in his cell playing his guitar and watching television. When asked how he was, the man said he was "fine".

### **Monday 10 December**

87. No real change in the man's behaviour was reported on 10 December. He remained in his cell all morning but engaged with staff during their checks. For the most of the day, the man appeared to be sleeping or watching television in bed. Staff spoke to him at lunch time and during evening association and on both occasions the man said he was okay. He once more declined to leave his cell to collect any of his meals.
88. At 8.15pm that evening, an Officer Support Grade (OSG) began his night duty on house block 1. All prisoners had already been locked in their cells for the night. The OSG collected his folder containing an anti-ligature knife (known as a fish knife because of its shape), torch and pouch of keys (cell keys within a sealed pouch for emergency use only) from the orderly office. He also received information about those prisoners on open ACCT documents, and received a verbal handover from the officer on the wing. He was not informed of any concerns.
89. When the OSG checked the ACCT documents, he noticed that the man had been placed on an hourly watch. Although not unusual, he thought that this level of observation was high and checked with the Orderly Officer on duty, who confirmed that this was correct. He then commenced his normal duties which included checking on all those subject to ACCT procedures.
90. At interview with my investigators, the OSG said that, although he had not been ACCT trained, he understood the principles behind it. Upon checking the man's cell at 8.30pm, he noticed him sitting on his bed watching television. The OSG asked the man if he was okay to which he nodded in response.
91. When the OSG checked the man at 10.30pm, he observed the man writing at his desk. Seeing a guitar in the cell, he engaged in a brief conversation with the man about it. When the man was checked at 11.30pm, he was standing up arranging paperwork that was on his bed. Again the man responded by nodding his head at the OSG who asked if he was okay.
92. At 1.00am, the OSG shone his torch through the cell observation panel of the man's cell as the cell light was switched off. The man appeared to be in bed asleep and the OSG had no concerns about him. Further

checks were logged at 2.00am and 3.00am, with the man appearing to remain asleep.

93. The OSG started patrolling the wing again at 4.15am. He arrived at the man's cell and again used his torch to look in to the cell. On this occasion, he noticed that the man was out of bed and apparently standing up. The battery went flat as the OSG shone the torch from the man's feet to his head. The OSG said he immediately turned the cell light on. He saw the man hanging from his wardrobe by a white ligature which was tied around his neck. He described the man as looking pale, with saliva coming from his mouth.
94. The OSG used his radio and alerted the control room to a 'Code 1' emergency (the code for prisoners with chest pains, hanging, or an immediate threat to life). He also requested Hotel 2 (a call for the healthcare officer on duty). An ambulance was requested by the control room.
95. The OSG told my investigators that he did not go into the cell because he had been told that he should not do so unless two officers were present. He had not been trained in first aid. When other staff arrived, the OSG made his way to the office to replace the batteries in his torch and continue his duty.
96. A fourth SO said he responded to the Code 1 emergency call. Three Officers also made their way as quickly as possible to house block 1. One Officer told my investigating officers that he arrived at the man's cell within 45 seconds of the call. As one of only two cell key holders (the other being a SO) he opened and went into the cell with another Officer. Both officers saw the man hanging. An SO immediately contacted more staff to assist and appointed others to escort the ambulance when it arrived.
97. An Officer told my investigators that the man had made a plaited rope and tied it around the wall cupboard in the corner of the cell. Another Officer cut the ligature with his fish knife. The Officer supported the man's body and the two officers then laid the man on the floor. One Officer said that the man's lips had curled back and he was cold.
98. Another Officer also responded to the emergency call. At interview, she told my investigating officers that she arrived at the man's cell as the other two officers were supporting the man's body. She assisted and moved the cell furniture so that the man could be laid flat on the floor. She then checked to see if the man had a pulse but found none.
99. The officers were about to commence cardio pulmonary resuscitation (CPR), when a Nurse arrived. One Officer said this was about 20 seconds after he had arrived at the cell. The Second Officer left the cell and made her way to the main gate to meet the paramedics. It was a cold night and, en-route to the gate, she experienced difficulties

unlocking a number of the outside gate locks because of the freezing temperatures.

100. At interview, the Nurse told my investigators that he responded to the emergency call at 4.23am. He immediately made his way to house block one, en route meeting the SO who explained that a prisoner had been found hanging.
101. They arrived at the cell and saw the man lying on the floor with his head towards the cell window. The Nurse immediately checked the man for signs of life. He was pale in colour and cold. Salivation fluid was also leaking from the right side of his mouth. The man had no pulse or blood pressure and was not breathing. The Nurse told my investigators that, in his opinion, the man showed no signs of life. Nonetheless, he commenced external cardiac compressions.
102. At interview, another Nurse told my investigators that, on hearing the radio call, he collected the red emergency bag (which contains equipment to aid resuscitation) from the healthcare unit and made his way to house block 1. He arrived at the man's cell within two minutes. Whilst the other Nurse carried out cardiac compressions, the newly arrived nurse inserted an airway, connected an ambu bag (an artificial breathing aid) and set up the oxygen supply. This Nurse also carried out a full assessment of the man and concurred with the other Nurse that he showed no signs of life.
103. An Officer met the paramedic from the fast response unit at the prison gate at 4.35am. At 4.43am, a SO received a telephone call from the main prison gate informing him that an ambulance crew with two paramedics had also arrived. The officer was at the time in the process of escorting the first response paramedic through the prison. She told my investigators that she had to deliver the paramedic to the man's cell first, before she could return to collect the ambulance crew.
104. An SO said that night staffing levels are much reduced compared to those of the day shifts. He said that it was inevitable that there was a delay before the ambulance was escorted through the prison as staff were already in the midst of escorting the first paramedic. Staff on duty told my investigators that the ambulance crew were verbally aggressive with them because of the delay.
105. Another Officer was on duty that night and received a telephone call from an SO informing him of an emergency on house block 1. The officer had been unaware because the batteries in his radio were flat. He made his way as quickly as possible to the man's cell arriving at the same time as the first response paramedic.
106. When the paramedic arrived at the cell, he was briefed by the two prison nurses. The paramedic then continued to examine the man and attached a portable defibrillator which continued to instruct the user not to shock, meaning there was no cardiac activity. The paramedics asked

the SO to make contact with the ambulance paramedics to ensure they brought a stretcher and a 12 inch ECG lead to the cell.

107. When the ambulance paramedics arrived at the cell, they discussed what action to take next with the first response paramedic. Two nurses left the cell to make their entries in the man's medical record.
108. One of the officers told my investigators said that the paramedics said they intended to continue to attempt resuscitation on the man as he "was a young lad". They meant by this that, given the man's age, they believed there was a possibility he could be revived. The man was transported into the ambulance and taken to the Epsom Hospital. A fourth SO said that, although the prison staff believed that the man was already dead, the ambulance crew were not forthcoming with any information about his condition. He therefore instructed an Officer to accompany the man in the ambulance, none of the paramedics having officially pronounced his death.
109. The second Governor was the duty governor responsible for the prison on the night of the man's death. He told my investigators that he was contacted at home at around 4.40am by the prison's communications officer. The officer explained that the man had committed an act of self harm by suspending himself with bed linen around his neck from his cell cupboard. Resuscitation was being attempted. The Governor made his way into the prison. On the way, he was updated by the Officer who was instructed to accompany the man in the ambulance on the man's status and told that the man had been taken to hospital.
110. The ambulance crew left the prison and continued to try and resuscitate the man on route to Epsom Hospital. When they arrived, a team of doctors were on hand to take over and the man was immediately taken into a room where resuscitation continued. The Officer told my investigators he watched the doctors try to revive the man. He was eventually pronounced dead at 5.42am.
111. The police arrived at the hospital soon afterwards and were updated on events. The Officer contacted the prison to inform staff of the man's death.

### **After the man's death**

112. As the second Governor's journey took approximately 40 minutes, he telephoned the control room again for an update before arriving at the prison. On this occasion he was told that the man's death had been pronounced at the hospital. The SO had instigated the prison's death in custody contingency procedures and contact was being made with the appropriate agencies.
113. The police arrived at the prison at 6.00am, as did the Governor. The man's cell had already been sealed awaiting their arrival. The Governor

then spoke to a number of staff and assisted the police. Instructions were given to collate the man's records including details of his next of kin.

114. At around 7.10am, arrangements were made to review all the other prisoners who were currently on an open ACCT. The Governor made arrangements for the night duty staff to congregate in the orderly office so that they could complete incident reports. This was followed by a hot debrief meeting at 7.45am. The officer arrived back from the hospital in time to attend. Staff were given the opportunity to go through the events of the night, and support was offered.
115. Another SO arrived on duty to be informed of the man's death that morning. She told my investigating officers that, as the prison's family liaison officer (FLO), she immediately obtained the man's next of kin details. Within an hour and accompanied by a fourth Governor, she left the prison to inform the man's family of his death. When they arrived, they were met by the man's mother and stepfather. The man's mother told the SO that the man had said he would take his own life. She was concerned that he had done so with the strings from the guitar that she had recently brought into the prison for him. The SO was able to confirm that the man had not used the guitar strings.
116. At interview, the SO told my investigators that they gave the man's parents as much information as possible, including the coroner's details and prison contact numbers. The family were also offered the opportunity to visit the prison.
117. The SO said that the man's parents asked for further information about funeral costs and the return of his property. The SO said that she told the family that the prison would offer financial assistance for the funeral.
118. The man's parents were originally informed by this SO that the prison would pay up to £2,000 towards funeral expenses. The family later told the prison that the cost of the man's funeral amounted to £3,279 and asked if the prison would be able to contribute further. The matter was passed to the Governor of High Down. I understand there was a delay of a week before the full payment was authorised.
119. The SO and two other members of staff attended the man's funeral. At that stage, the man's personal property had not been returned to his family. The SO told them that she would make arrangements for the property to be returned as soon as possible. Due to her annual leave, she was unable to do so the following week, during which time the man's family again enquired about the return of his property. No arrangement had been made in the SO absence to return the property. On her return from leave, the SO arranged for the man's property to be returned.

### **Letters found in the man's cell**

120. After the man's death, a number of letters were found in his cell. The majority were dated 6 December 2007, and were addressed to friends and family members expressing his wish to distribute his belongings to specific people. He made it clear that it was his intention to kill himself, and referred to longstanding issues to do with his lifestyle and relationship difficulties. The man also mentioned that he believed he would be sentenced to 25 years in prison.

### **Post Mortem**

121. The conclusion of the post mortem examination was that the cause of the man's death was hanging.

## ISSUES RAISED IN THE INVESTIGATION

### Clinical care

122. On arrival at High Down, the man was immediately located in the healthcare unit and an ACCT document was opened. Further to this, he had contact with and was monitored by a number of healthcare staff. The clinical reviewer notes that this included the man being assessed by the visiting prison psychiatrist during three ward rounds.
123. The psychiatrist was a member of the mental healthcare In-Reach team. However, the man was not referred to the In-Reach team for a secondary assessment. The In-Reach Manager confirmed to my investigators that it was clear from the entries in the man's ACCT plan that a referral was intended. However, one was not made and so no follow up action took place in spite of the team being part of the ward rounds.

#### **The Head of Healthcare should ensure that all follow up actions in ACCT plans are carried out.**

124. The clinical reviewer highlights that prisoners should be seen by members of the In-Reach team after being specifically referred to them, and not simply on an ad hoc basis when the team happen to be present. This would clarify the position in respect of in-reach involvement and follow-up. In particular, there would be no need for a separate referral to in-reach for follow-up when a patient is discharged from healthcare.
125. The clinical reviewer also comments that, in the community, mental health teams benefit from all referrals entering the system in the same way. It might be helpful if this approach were adopted by the Mental Health In-Reach team who provide secondary psychiatric services to the prison population.
126. At the time of my investigation, prisoners assessed by a member of the In-Reach team were seen as a referral to the team rather than to individual members (such as the psychiatrist). I am pleased to learn that the healthcare unit has recently reviewed its procedures, and this practice has now been changed so that any patient admitted to the unit for inpatient care will be allocated a named nurse and has a full mental health nursing assessment within seven days of admission. Any patient admitted with a mental illness will be automatically referred to the In-Reach team. I therefore do not make a formal recommendation.
127. The clinical reviewer also considers that the In-Reach team would benefit from the input of a psychologist.

#### **The Head of Healthcare should ensure that the revision of their new procedures relating to referrals and discharge from the In-Reach team is promulgated to all relevant staff.**

**The Head of Healthcare should review the benefits of having a psychologist within the In-Reach team.**

**Relocation of prisoners from the healthcare in-patient unit**

128. Upon being relocated to the normal prison house block, the man was not subject to a detailed planning process that would have assisted wing staff to identify any signs of deterioration. Staff did not receive clear guidance about what to observe and when to ask for further intervention or assessment. The prison healthcare manager confirmed to my investigators that it was their expectation that prisoners discharged from the healthcare unit should receive a routine check within a week. Unfortunately, this did not occur when the man was discharged because of staff shortages. The unit had no further contact with the man once he was moved to the wing.
129. It is beneficial for there to be a multidisciplinary approach to prisoner aftercare, as well as a formal review, so that appropriate staff have an opportunity to input into the prisoner's care. As part of the healthcare review since the man's death, all patients' discharge plans now include an offer of an out-patient appointment.

**ACCT monitoring**

130. So far as they could judge, my investigators found that staff accurately reported their observations and interactions with the man. At the time of his death, he was expected to be monitored every hour. However, there was an interval of one hour and 20 minutes between the final two checks.
131. The clinical reviewer notes that an hourly frequency can provide an opportunity for an individual to self harm between observations. In fact, this is true of any level of observations short of constant. However, as the Chief Inspector of Prisons has noted in her most recent inspection report on High Down, checks by night staff on prisoners subject to open ACCT documents should be frequent and unpredictable. This is to avoid the prisoner being able to predict when he is going to be observed by staff. Had the man been checked upon 20 minutes earlier (say at 4.00am), it is far from certain that the outcome would have been different. However, the Governor will wish to assure himself that night-time ACCT checks are being carried out appropriately.

**The Governor should review the timeliness of night-time ACCT observations.**

132. The issue of observations aside, it is clear from this investigation that many staff tried to improve the man's mood by engaging him in conversation. I am also impressed by the decision to allow his mother to bring in the man's guitar and let him keep it in his cell.

**The Governor should commend the relevant staff named in this report for their efforts in offering support and care to the man.**

133. At interview with my investigators, the healthcare manager said that the ACCT documentation was only used by prison staff. I do not know if this view is shared by others, but all staff should be reminded that the ACCT process works best when everyone contributes, with entries made by wing, health and in-reach staff.
134. The OSG on duty the night the man was found hanging was not trained in ACCT procedures although he was aware of the principles behind it. I recommend that all staff who have contact with prisoners receive at least basic training on the ACCT document.

**The Governor should provide ACCT training for all staff who have contact with prisoners.**

**Night duty staff**

135. A number of issues came to light during this investigation relating to night staff. An OSG's torch failed to work because the batteries were flat when he arrived at the man's cell. The batteries also failed in an Officer's radio (the main means of communication). As a result, he was not immediately aware that an emergency had been reported elsewhere within the prison. Equipment failures can have a significant impact on the speed of response to incidents. Steps should be taken to ensure that all prison radios and torches are fit for purpose at the beginning of staff duty.

**The Governor should ensure that radio and torch batteries are regularly changed to avoid their failure whilst staff are on duty.**

136. When the man was first discovered, an OSG did not enter the cell. He observed the man in what was considered a life threatening position, hanging by a ligature and with saliva was coming from his mouth. The prison's night procedures say that "saving life is paramount and aid must not be delayed whilst waiting for support staff to arrive". However, they also state that personal safety is to be considered before entering a cell. The OSG told my investigators that his instructions from his senior managers were that he should never enter a cell unless two officers are present.
137. The night procedures require staff to make a judgement about when to enter a cell in emergencies. Staff must decide whether they think a life is in danger, and whether they believe there to be a risk to the security of the prison. I have now conducted many investigations in which staff across the prison estate have had to make such a decision. On some occasions they have entered the cell; on some occasions they have not.

I have been loath to deploy the certainty of hindsight when considering the reasonableness or otherwise of those decisions.

138. Nor do I criticise the OSG's actions in this instance. In any event, assistance arrived at the man's cell very quickly and I believe it unlikely the OSG's decision to stay outside the cell had any detrimental impact on the events that followed. The OSG was not first aid trained and would have been limited as to what he could have done for the man without further support.
139. However, it would be wise for the Governor to review the night procedures to ensure there are no avoidable ambiguities. In particular, I note that the OSG has said that his instructions were never to enter a cell alone (in contradiction to the formal policy).

**The Governor should review the night procedures and ensure that all night staff are aware of what is expected of them.**

**The Governor should review the level of first aid training amongst night duty staff and where necessary ensure such staff receive additional training.**

### **Emergency Services**

140. Prison staff reported to my investigators that the ambulance crew were unhappy about the delay before they were escorted to the man's cell. It is perhaps inevitable that delays can sometimes occur during the night state when there are reduced staffing levels. I am pleased to note that the clinical reviewer has already addressed this matter with the ambulance service.

**A familiarisation exercise has already been carried out by the ambulance service regarding prison procedures for emergency vehicles, particularly at night when staffing levels are reduced. I note this as good practice.**

### **Funeral expenses**

141. Support for funeral costs is addressed in Prison Service Order (PSO) 2710. The PSO says that the prison should:

“... offer to pay reasonable funeral expenses or, if the family want particularly expensive arrangements, offer a contribution. £3,000 is the sort of figure considered reasonable in 2005-2006 but not to quibble over small sums. This offer should be made irrespective of whether the family is entitled to claim a grant from the Social Fund.”

142. My investigator found that the family liaison officer was unaware of the information in this PSO. This led to the wrong information being given to the family which resulted in an unnecessary delay in payment being

authorised for their expenses. I believe that the delay in dealing with this matter has contributed to the family's sense of disappointment with the prison and make the following recommendation.

**The Governor should ensure that all family liaison officers are aware of the current PSO guidance and the information is explained to the next of kin as soon as practicable.**

## CONCLUSION

143. The man was a young man who had a history of self harm and mental health difficulties, and had expressed an intention to take his own life well before entering Prison Service custody at HMP High Down. When he was received at High Down, on remand for murder, he spent three weeks in the healthcare unit where he was assessed and monitored as part of the healthcare unit regime and by virtue of being on an open ACCT. He then spent a further three weeks on a mainstream prison wing where he seems to have been well supported by wing based staff. Aware of the man's talent for playing musical instruments, staff managed to engage him in some musical activities within the prison. In spite of this, the man's outlook on life remained unchanged and he maintained his intention to take his own life throughout his short stay in custody.
144. It appears that the man did not believe that things would improve, and the letters found in his cell after his death support this view. I do not believe that there were actions that prison staff could reasonably have been expected to have taken that would lead to a different outcome.

## **RECOMMENDATIONS**

1. The Head of Healthcare should ensure that all follow up actions in ACCT plans are carried out.
2. The Head of Healthcare should ensure that the revision of their new procedures relating to referrals and discharge from the In-Reach team is promulgated to all relevant staff.
3. The Head of Healthcare should review the benefits of having a psychologist within the In-Reach team.
4. The Governor should review the timeliness of night-time ACCT observations.
5. The Governor should review the level of ACCT training amongst all staff who have contact with prisoners.
6. The Governor should ensure that radio and torch batteries are regularly changed to avoid their failure whilst staff are on duty.
7. The Governor should review the night procedures and ensure that all night staff are aware of what is expected of them.
8. The Governor should review the level of first aid training amongst night duty staff and where necessary ensure such staff receive additional training.
9. The Governor should ensure that all family liaison officers are aware of the current PSO guidance and the information is explained to the next of kin as soon as practicable.

### **Good practice**

10. The Governor should commend the relevant staff named in this report for their efforts in offering support and care to the man.
11. A familiarisation exercise has already been carried out by the ambulance service regarding prison procedures for emergency vehicles, particularly at night when staffing levels are reduced.

The Prison Service has accepted seven of the recommendations and partially accepted the remaining two. Their action plan is attached as an annex.