Investigation into the circumstances surrounding the death of a man at HMP Swaleside in January 2009

Report by the Prisons and Probation Ombudsman for England and Wales

January 2010

The man was 21 years old when he died in January 2009 in his cell at HMP Swaleside. He was found hanging. The investigator and Family Liaison Officers (FLO) join me in offering our sincere condolences to his family and friends for their sad loss.

I wish to thank the Governor of Swaleside for making the necessary facilities and information available to the investigator. I also wish to pay thanks to the Principal Officer for his assistance.

In the course of the investigation, I asked for a clinical review to be carried out into the medical care and treatment the man received in custody. The clinical reviewer was appointed by the local Primary Care Trust to undertake a clinical review, and I am grateful for their assistance and her report. I must apologise for the delay in issuing the report. This has been caused by the number of cases coming into the Ombudsman's office and the availability of investigators.

Whenever a young man takes their own life, it is right that questions are asked as to whether anything could have been done to prevent this happening. This investigation concludes that he gave no indication to staff that he was planning to do so and that, although he had a history of harming himself, he had not done so in the months before his death. There are concerns, however, about the effectiveness of health screening procedures which are reflected in the report. The report makes four recommendations and identifies one area of good practice.

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

Jane Webb
Deputy Ombudsman **January 2010**

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SUMMARY

In March 2007, the man was arrested and taken into police custody where he remained for two days. After an appearance at the magistrates' court, he was remanded into prison custody and taken to a young offender institution on the outskirts of London.

When the man arrived at the prison he told prison staff that he had thoughts of self harm. An ACCT document (a form used to help monitor individuals at risk of suicide or self-harm) was opened and support mechanisms put in place to protect him. As part of that protection, he was seen and assessed by medical staff. He told a psychiatrist that he would not harm himself. The psychiatrist deemed that the man was not suffering from a mental illness, although he was anxious about his situation. The ACCT document was closed on 23 March.

The man remained in custody and, in March 2008, was found guilty of the charges against him. He was sent back to prison to await sentencing.

In the meantime, and as a result of a road traffic accident which occurred sometime earlier, he was referred to a London hospital for orthopaedic treatment to a knee injury.

At the end of March, the man was sentenced to life imprisonment, with a recommendation that he serve at least eight years. He was taken to HMP Belmarsh to begin his sentence.

In April, the man hurt himself by trying to remove a tattoo using boiling water. The injury caused a blister, which was treated with antibiotics.

The following month, the man asked to speak to a Listener. The officer dealing with the request noticed a small amount of blood on the cell floor. As a result, the officer opened another ACCT document. Following an assessment, the document was closed and this appears to be the last occasion that he was monitored under ACCT procedures.

In September, the man transferred from Belmarsh to Swaleside. The transfer was arranged at his request because he wanted to be with other life sentence prisoners.

Two months later, the man underwent surgery on his damaged knee. The surgery went well and his injury healed up. Nothing more was noted about his health and well-being.

During the early morning roll check carried out in January 2009, a prison officer found the man hanged in his cell. The officer and a colleague went into the cell and cut the ligature from around his neck. After placing him onto a bed, they realised that rigor mortis was present and that it was too late to attempt to revive him.

I make four recommendations. These concern first reception healthscreening at Swaleside, the computerisation of medical records and the introduction of an

emergency code system. The report also highlights an area of good practice, that Listeners were made available to other prisoners after the man's death.

THE INVESTIGATION PROCESS

1. After receiving notification from the Prison Service in January that the man had died, a senior investigator was appointed to carry out the investigation. He contacted the Governor and arranged to travel to the prison to meet him and his team for the purpose of opening the investigation.

2. In January, the investigator arrived at the prison where he met the Governor. Also at that meeting were:

    - The Principal Officer appointed by the Governor to act as the prison's liaison officer for the investigation,
    - The prison's Family Liaison Officer,
    - A representative of the local Independent Monitoring Board (IMB),
    - The Operational Manager, Deputy Head of Security,
    - The Senior Officer, Safer Custody Manager,
    - The Healthcare Manager
    - An Officer (Secretary) and Principal Officer (Chairman) representing the local Prison Officers Association,
    - The prison's chaplain.

3. The Governor had arranged for a number of those attending the meeting to give the investigator an overview of what had occurred in January. The briefing helped him identify a number of people that he wanted to speak to at a later date. In addition, others attending the meeting gave background information about the man.

4. The prison's Family Liaison Officer told the meeting about his contact with the man's family. He said the Governor had offered to assist his family with funeral costs.

5. The Deputy Head of Security reported that following the man's death, he had identified his next of kin and passed the details to the chaplain so that he could break the news to the family. In the meantime, an unknown prisoner at Swaleside had used an illegal mobile telephone and contacted one of the man's sisters and told her. She in turn telephoned the other sister to tell her that the man had died. Whilst the chaplain was being briefed, the second sister rang the prison to ask what had happened to her brother. I understand that the man's family are satisfied that the prison was in the process of telling them and the explanation given for the way they were told.

6. The investigator was also told that the man's two sisters had been to the prison and seen the cell where their brother lived and died. They were allowed to enter the cell, say their own prayers and light candles. They met the Governor and the chaplain arranged a memorial service for the following week and invited the man's family to attend.

7. After the meeting, the investigator went to the cell where the man was found. He was able to view the cell and see where the ligature was attached. Although no final letter was found in the cell, the investigator did find a short

message written on the inside of the cell cupboard door. Written on the door was “It is over, never again x x”. It is not known whether the message was written by the man, or a previous occupant. The investigator made the Governor aware of the note and asked for the message to be photographed as part of the investigation. Additionally, he asked that the Coroner’s Officer be given a photograph to assist the inquest.

8. Following any death in prison, a notice to staff and prisoners is published inviting anyone with information, to make themselves known to the investigator. The notices were clearly displayed around the prison and available to prisoners and prison staff.

9. In February another investigator, assisted with the investigation by carrying out joint interviews with the clinical reviewer. Three days later, the first investigator returned to the prison and over the next four days he interviewed members of staff. On 11 February, the first investigator was joined by the clinical reviewer and they jointly interviewed staff and the prison Senior Medical Officer.

10. In the meantime, the Family Liaison Officer had been in contact with the man’s family. She explained the role of the Ombudsman and offered his family the opportunity to meet her and the investigator. The purpose of offering the meeting was for his family to contribute towards the report and ask any questions they would like me to examine. At the time of issuing the report, the man’s family have not asked to meet the investigator. I hope that my report answers the majority of their questions. There is one question, however, that the investigator has been unable to answer. They told the Family Liaison Officer that another prisoner reported that the man had had an argument with an officer the night before he died. The investigator has been unable to shed any light on this issue.

11. Sometime after his death, the investigator was told by the prison liaison officer that a note apparently written by him to his family had been found by police. A copy of the note has been passed to the investigator for his consideration.

HMP SWALESIDE

12. The prison is situated close to the village of Eastchurch, on the Isle of Sheppey, Kent. It is a modern purpose built prison and forms part of the Sheppey Cluster which is an amalgamation of three prisons, HMP Elmley, HMP Standford Hill and Swaleside.

Anti Ligature Knives

13. Staff in contact with prisoners are issued with specially designed anti ligature knives, commonly referred to as “fish knives”, which are used in an emergency to remove a ligature. The knives have a concealed blade which is placed against the ligature and pushed forward to cut it without harming the prisoner.

Assessment, Care in Custody and Teamwork (ACCT)

14. ACCT requires staff to identify any concerns, take action, and document those actions for prisoners who are identified as at risk of suicide or self-harm. The ACCT document should be available to all staff where the prisoner is located. Within 24 hours of the document being opened, the prisoner will be seen by a trained ACCT assessor and have a case review meeting, which is a multi disciplinary meeting. The meeting draws up a care and management plan, known as a CAREMAP, and a member of staff is nominated as the case manager. Wing managers take on the role of case manager, oversee the management of the ACCT document and attend case reviews.

Care Team

15. Each prison has its own care team. The members are drawn from all areas of the prison and trained specifically to help and support prison staff. Following any serious incident, they provide an invaluable role to any member of staff who requires support.

Emergency response codes

16. In the event of urgent medical assistance being required, a number of prisons have chosen to adopt codes to alert medical staff to particular incidents. The most common are code red and code blue, although some prisons have opted for code one and code two. Code red or one informs the medical staff that the patient is bleeding. Code blue or code two alerts them that the patient is in breathing difficulty.

17. At Swaleside there are four codes in use:

- Code 1. Hanging, unconscious state, heart attack or severe chest pain
- Code 2. Severe cutting, stabbing or severe blood loss
- Code 3. Epileptic fit, asthmatic attack or burns and scalds
- Code 4. Injuries related to falls, back and leg injuries or sports injuries

Her Majesty's Chief Inspector of Prisons

18. Her Majesty's Chief Inspector of Prisons reports on all Prison Service establishments. The majority of inspections are announced and allow the prison to prepare for inspection. However a number of inspections are carried out without prior warning and are known as unannounced inspections.

19. In March 2008, the Chief Inspector carried out an announced inspection of the prison. In her report introduction, she said the prison was safe and respectful, which she added was impressive given the many serious offenders held there. Additionally, the Chief Inspector said that anti bullying and suicide and self harm arrangements were good and that prisoners felt significantly safer at Swaleside than at comparable prisons.

20. The Chief Inspector went on to say that staff–prisoner relationships were a particular strength and supported by an effective personal officer scheme. However, in contrast, it was noted that prisoners complained about the attitude of healthcare staff. The report adds that the inspection team noted reluctance among some healthcare staff to modernise and develop services. In her report, the Chief Inspector said:

> "Health services offered prisoners access to a broad range of clinical specialisms in the prison and through external NHS sources. The management of long-term illnesses was good, as was the GP service. Dental services did not meet the needs of prisoners, and the lengthy waiting lists would grow with the increase in prisoner numbers. Relationships with the Primary Care Trust were developing well, and the healthcare team benefited from the strong support of the Governor. Despite the positive aspects, prisoners were extremely dissatisfied with perceived poor attitudes by healthcare staff, who they claimed denied them access to some services".

21. In the final paragraph of her introduction, the Chief Inspector said that Swaleside had to manage a challenging population of serious offenders. She added that it was commendable to find a very safe prison and pleasing to find good staff – prisoner relationships.

22. As part of the inspection, the Chief Inspector examined 115 ACCT documents opened in 2007. The Chief Inspector said the quality of the documents was mixed and that some assessments lacked detail. There was also some evidence of a lack of a multidisciplinary approach. The report went on to say that the management arrangements for suicide and self–harm prevention were good.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB). Its role is to monitor the prison and to report any concerns that they have regarding the prison, or how prisoners are treated. The Board reports to the Secretary of State and their reports are available to the Governor. Board members are able to visit any area of the prison at any time and have direct access to any prisoner who they wish to see, or who requests to see them. The Board holds regular meetings in the prison, with the Governor attending for part of the meeting. The Chair of the Board produces an annual report to the Secretary of State for Justice.

24. In the latest report covering the period 1 May 2007 to 30 April 2008, the IMB Chair for Swaleside said in her executive summary that the prison was well run. She added that staff–prisoner relationships were excellent. She said there were ongoing problems with clustering and outside services, including healthcare. The IMB Chair said:

> "… there have been many complaints from offenders and staff concerning healthcare – there was a situation of them and us – communication seemed to be sadly lacking…Proactive plans have been put in place to improve matters …"

25. With regards to deaths in custody, the IMB Chair said the Board were concerned at the length of time taken to deal with inquests. She added that the delays are stressful, both for families and for prison staff.

Listeners

26. The prison has a "Listener Scheme". The Samaritans train selected prisoners to be the first contact for any prisoner who feels vulnerable and at risk. The scheme is confidential and any prisoner can ask to speak to a Listener at any time of the day or night. Prisoners can access a Listener easily by speaking to a member of staff, who arranges for a Listener to speak to them. During the hours that prisoners are locked in their cells, anyone wishing to speak to a Listener can make the request to the staff on duty. The night orderly officer has the authority to unlock a Listener and to escort him to the cell of the prisoner who is requesting assistance.

Police investigations of deaths in custody

27. The police are notified by the prison as soon as the death is discovered. In the first instance, the police treat the area where the person is found as a crime scene and, as part of their investigation, note the names of everyone involved and those who have been in contact with the body. Additionally, they note the identity of those entering and leaving the cordoned area. It is only when the police are satisfied that the death is not suspicious that the Ombudsman's investigators are allowed to begin their own enquiries.

Prison officer grades

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

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

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

31. In addition to prison officer grades, there are a group of staff known as Operational Support Grades (OSGs). OSGs wear prison uniform and carry keys but do not carry out the same function as prison officers. Their role is to support the areas of the prison where there is little or no prisoner contact, for example, the main gate.

Roll checks

32. In order to check the roll, the officer opens the cell door observation panel and looks into the cell. The officer checks to confirm that the prisoner is in the cell and that the correct number of prisoners is accounted for.

KEY EVENTS

March 2007

33. In March, the man was arrested at his home address for the attempted murder of a police officer. He was taken to a Police Station for questioning. Whilst in the police station, he made superficial cuts to his arms using a plastic fork.

34. Two days later, the man appeared before the Magistrates' Court, having been charged with possession of a firearm with intent to endanger life, and possession of a prohibited weapon. He was remanded into custody and taken to Her Majesty's Young Offender Institution Feltham.

35. When the man arrived at Feltham, he told an Officer that he had thoughts of suicide and self harm. He told the Officer that being in a cell would contribute to his suicidal thoughts. An ACCT document was opened and he was placed on three observations day and night and given telephone access to the Samaritans.

36. The ACCT assessment section completed by an assessor shows that the man's main concern was being away from his sisters. He told the assessor that he was charged with an offence that he did not commit and, once he knew his sisters were alright, he would kill himself. He also said he had attempted to kill himself after his mother died by trying to hang himself at his sister's house.

37. In March, the man was assessed by a psychiatrist as part of the ACCT process. He repeatedly told the psychiatrist that he would not harm himself. The psychiatrist found no evidence that he had a mental illness.

38. As well as seeing the psychiatrist, the man was referred to an occupational therapist. The reason for the referral was as a result of the earlier road traffic accident and the knee injury he had suffered.

39. The final entry in the ACCT document was made at 9.00am in March, after which it was reassessed and closed. The man appears to have settled down reasonably well afterwards.

40. In September, the man was seen by a psychiatrist, although the reason is not clear from his medical notes. No evidence of serious mental illness was found. The psychiatrist did, however, find that he had anxieties related to his circumstances.

41. The man attended three counselling sessions during November. He was assessed as being highly anxious and frustrated. He used the sessions as an opportunity to offload as he found it difficult to relate to his circumstances and lifestyle changes. He also continued to see the occupational therapist.

42. Over the next few months the man appears to have settled in well. He continued to go to appointments with the occupational therapist. In December he went to healthcare as he had grazed his left forearm.

March 2008

43. In March 2008, the man was found guilty at Crown Court. Although found guilty, he was not sentenced at that point but was remanded back into custody to await sentence.

44. The following month, in April, the man was due to attend an orthopaedic outpatient appointment at hospital to have his accident injury treated. He did not attend although the reason is not clear from the medical records why not and the missed appointment was rescheduled for the following month.

45. Seven days later, the man was sentenced to life imprisonment with a recommendation from the judge that he should serve a minimum of eight years imprisonment. Following the court appearance, he was taken to HMP Belmarsh.

46. Unlike the previous few months, the man's behaviour in April was far more significant. He tried to remove a tattoo on his left arm by pouring boiling water onto it. The injury caused a blister which required treatment with antibiotics.

47. In April the man was due to attend the rescheduled orthopaedic appointment, but once again, he did not go. As with the previous appointment, it is not known why he did not attend. A further appointment was made for later in the year.

48. The man had another appointment with the psychiatrist, whom he had seen previously in April. He was assessed as anxious, frustrated and angry at the judge for his eight year tariff. He did not, however, display any suicidal thoughts or plans. As he had a poor sleep pattern, he was prescribed diazepam, a mild tranquilliser.

49. In May, at 11.55pm, the man pressed his cell emergency call button. An officer went to see why the call had been made. He asked the officer if he could speak to a Listener. The officer looked into the cell and noticed blood on the floor. The man would not tell the officer where the blood had come from, nor would he show the officer his left arm.

50. As a result of the injury, the officer opened an ACCT document shortly afterwards. In the "cause for concern" section of the form he noted the request for a Listener and that he had seen blood. The action plan shows that the man was to be monitored every hour and given a Samaritans telephone to use. He was also allowed to speak to a Listener.

51. The man was treated for his injuries by healthcare staff. He told the nurse that he had had a disagreement with another prisoner the previous evening. He said he felt stressed and did not feel that the diazepam was working.

52. Following an assessment, the ACCT document was closed later the same day. The man told prison during the assessment that he was embarrassed about hurting himself and said he had no further thoughts of self harm or suicide. It would appear from prison records that this was the last occasion when he was monitored under the ACCT procedure.

53. A further orthopaedic appointment scheduled for June was cancelled. The reason for the cancellation was because of a security matter. It appears that the prison escort risk assessment document had not been signed in time for the escort to take place. (Escort risk assessments are required before any transfer).

54. Later that month a letter was received from hospital offering the man an appointment for surgery in August. It was unclear from his medical record when he was assessed or when the decision had been taken. It is also not clear why the appointment did not take place.

September

55. In September, the man transferred from Belmarsh to Swaleside. The reason for the transfer was that, at his request, he wanted to move to a prison where there were other life sentence prisoners.

56. In her clinical review, the clinical reviewer said the man's medical record accompanied him to Swaleside. She said the standard Prison Service health screening document was completed and it said he was transferred unexpectedly. The doctor added that the document also noted that the man had a history of mental health issues (in this case, stress), aggressive behaviour and deliberately harming himself. No current thoughts of self harm were recorded. The man was prescribed tramadol for his knee injury and was recorded as having no other physical illnesses. There was no history of drug or alcohol abuse.

57. A Registered General Nurse (RGN) completed the assessment, but at interview said he could not recall meeting the man. The nurse said he was unable to remember whether he had read the man's medical record. Additionally, he could not explain why he had ticked the assessment form box to indicate that the man had a history of mental health issues and self harm, but had not explored it further, or written anything in his medical notes.

58. A locum doctor working at the prison saw the man the next day in the prison healthcare department. The man was referred to the orthopaedic department at hospital for examination of his knee injury. He was later referred by another doctor back to hospital.

59. The following month the hospital offered the man a pre-assessment appointment for November. Following this appointment, he was to be admitted for knee surgery.

60. The man underwent surgery on his right knee as planned. Before returning to Swaleside, he was issued with a five day supply of oxycone (a pain relief medication), along with paracetamol, codeine and diclofenac (an anti-inflammatory). When he arrived back at the prison, it was noted in his medical record that he was upset at not being allowed to keep the oxycone in his possession. He argued with a nurse that he should be allowed to keep it himself. He later apologised to the nurse for his behaviour.

61. In December, the man returned to hospital as an outpatient. The doctor who saw him was pleased with the progress he was making. X-rays were taken which showed that the surgery had gone well. A further appointment was made for him to return to the hospital six weeks later.

62. At approximately 8.20am, in December, the man was seen by a member of healthcare staff as he had bruising to the left side of his mouth. He told healthcare staff that he had fallen out of bed.

January 2009

63. In January, the man went as usual to the Friday Muslim service, which is held in the prison chapel. The prison Imam took the service. He told the investigator that he had been away for over a month and, after the service, the man stopped to talk to him and asked about his trip. He said that the man appeared to be fine and that he had no concerns for his safety.

64. The investigator asked the Imam if the man ever spoke to him about ending his life, or whether he had ever spoken about his mother's death. He said he had not.

65. The Imam told the investigator that the man converted to Islam whilst in Belmarsh prison. The Imam said he had received information from Belmarsh soon after the man arrived at Swaleside to say that he might have been bullied by other Belmarsh prisoners into changing his religion. After receiving the information, the Imam went to speak to him. He said the man denied being bullied into changing his religion. The Imam went on to say that the man regularly attended Muslim service and classes, which suggested to him that he was content with his choice.

66. Later that day, an officer saw the man. At interview she said that she knew him well, as he was one of the prisoners who cleaned the wing where she worked. She described him as helpful and pleasant and said that he had never given her any cause for concern.

67. The investigator asked the officer if the man ever said anything to her about being bullied into changing his religion. She said he had not. The officer was also asked if he ever spoke to her about his mother's death. The officer said that she did not know that his mother had died.

January

68. In January, an SO gave permission for the man to use a prison telephone to call his sister. He allowed the call as the man did not have any credit left on his telephone account. The SO said the man had been expecting some money to be sent to him, but it had not arrived and he wondered where it was. Additionally, although the man was being paid for working, his pay had not been transferred from his work account into his telephone account. This meant that although he had money available to use, it was not in the correct account. As this error was outside the man's control and could only be corrected by a member of the prison administration department, the SO attempted to have the man's pay transferred to his telephone account. However, the clerk responsible for prisoner accounts had gone home for the day, so the telephone account could not be credited until after the weekend.

69. The investigator asked the SO if he had any concerns about the man's safety at that time. He said he had not and that his behaviour was as usual. The SO asked an officer to supervise the call.

70. At about 3.00pm, the officer took the man to a room where he telephoned the number which he had given him. The officer told the investigator that he introduced himself and then allowed the man to speak to her.

71. Following the man's death, the officer made a note of the telephone call in his pocket note book. The officer noted that the man had been emotional, but calmed down, and was in a better mood when the call ended. The officer told the investigator that the man had been concerned about his nephew who had apparently developed a rash which he thought might be meningitis. His sister reassured him and the officer said he appeared more settled afterwards. The officer also noted that the man asked his sister to visit him. Additionally, the officer noted that he told his sister that he had not received some money from her but, when he did, he would allocate it to his telephone account.

72. At the end of the call, the officer spoke to the man's sister. His note of the conversation says that she thanked him for allowing the call. The officer said he tried to reassure the man's sister that her brother would be looked after and that he had some good friends in the wing. He said he had no concerns for the man's safety. He then spoke to the man for about ten minutes and offered to help sort out his money. The note ends by saying that he thanked the officer for the telephone call and that he appeared to be in a good mood. The officer said the man left the office and went into another prisoner's cell to play on a play station.

73. At interview, the officer said he knew the man well and spent some time with him when he was in hospital having the operation. The investigator asked the officer about the type of things the man would talk about. The officer said the man mainly spoke about his family, especially his nephew and sisters. The investigator asked the officer if the man ever mentioned anything to him about his mother's death or being pressurised into changing his religion. The officer said he had not.

74. After ending the telephone call, the man spoke to the SO and thanked him for allowing the call. The SO said he appeared cheerful and again gave him no cause for concern.

75. At about 4.40pm, the SO saw the man as he was collecting his evening meal. The SO said the man thanked him once again for the telephone call. The SO said there was nothing to suggest to him that the man planned to take his own life. He felt sure that, had there been, the prison could have helped him overcome whatever was troubling him.

76. The officer also saw the man collect his evening meal. The officer said the man thanked him again for the telephone call and appeared to be in a good mood. After collecting their meals, he and the other prisoners were locked up for the night.

77. As part of the investigation procedure, interviewees are entitled to have a union representative, or a friend with them. The officer was accompanied by another officer who acted as her friend. The officer's friend told the investigator that he had locked the man up that evening. He said the man had wished him good night and said "see you in the morning". The officer's friend said the man had not given him any cause for concern.

78. At about 7.30pm, the OSG began his night patrol duty in C wing. At interview he told the investigator that he was a regular member of night staff and for the majority of time worked in C wing. He said that when taking over for the night, he received a briefing from the outgoing member of staff and then went to count the prisoners to ensure that the wing roll was correct.

79. The OSG told the investigator that there had been no discussion about the man and he was not being monitored under the ACCT arrangements. He checked the roll at about 8.00pm and, although he could not recall anything specific about him, said he would have seen him as part of the roll check.

80. As the man was not being monitored under ACCT the next occasion when he was due to be seen, was the early morning roll check the following morning. This is normal Prison Service practice.

January

81. At about 6.00am, the OSG began the morning roll check. At interview he said the purpose of the check was to ensure that no one had escaped. The OSG said he was not expected to wake prisoners, but confirm that they were all present. He added that, to aid his view into the cell at night, the night patrol staff are issued with torches.

82. The OSG said he looked into every cell and confirmed that the roll was correct. He said that, although he looked into the cells, he could not recall anything specific about the man, nor did he remember seeing him standing in

the cell. After informing the night manager that the roll was correct, the OSG waited for a member of the day staff to arrive and take over.

83. At about 6.50am, the day officer began her duty on C wing. When she arrived into the wing she met and spoke to the OSG. She told the investigator that the OSG told her that the wing roll was correct.

84. At interview, the officer said she left the OSG in the wing office whilst she carried out a further roll check. She said that when she opened the observation panel of the man's cell and looked inside, she saw him standing in the centre of the cell, with a towel around his neck. The officer noticed that the man had a cigarette in his right hand and that his head was slightly tilted to one side. She said it was not unusual for him to be up early, but it was unusual for him not to speak to her. Concerned, the officer tried to attract his attention by knocking on the door, kicking it, and calling out his name, but could not gain a response.

85. Realising that something was wrong, the officer shouted to the OSG and asked him to assist her. The OSG looked into the cell and then suggested that the officer should contact the duty manager. The officer used her prison radio and asked the duty manager to attend immediately. At the same time the OSG unlocked the man's cell door and went inside, followed by the officer.

86. At interview, the officer and the OSG both said that when they went into the cell they noticed a thin ligature attached around the man's neck, which was secured to the cell light fitting. The officer removed her anti ligature knife and cut the ligature. She said the action of cutting the ligature caused the man to fall back, and in doing so, he banged his head against the wall. The officer and OSG picked him up and placed him onto the bed. The officer said that his body was stiff and there was no movement. (From the description given, rigor mortis was evident.) The officer said that she realised the man had died, and so she and the OSG left the cell, closing the door behind them.

87. Shortly after they left the cell, a PO arrived in response to the radio message. At interview he said the officer met him and appeared distressed. He said the officer told him that the man had died.

88. The PO said he looked into the cell and saw the man lying on the bed. He noticed that his skin tone was grey and cyanosed (a bluish colour associated with a lack of oxygen). The PO said that the man's tongue was protruding and his lips were blue. He went into the cell, checked for signs of life but did not detect any.

89. Using his prison radio, the PO asked the operator if an ambulance had been called and was told that it had. He told the radio operator that there had been a death. At about the same time, a nurse, a member of the prison healthcare staff arrived.

90. The nurse told the clinical reviewer that he was about to go off duty when he received an urgent call for him to go immediately to C wing. When he arrived,

the nurse saw that the man was fully clothed, his lips were blue and there was no sign of life. The nurse told the clinical reviewer that his body was stiff and in his opinion he had been dead for some hours.

91. Shortly afterwards, and in response to the request for an emergency ambulance, a paramedic arrived. The paramedic went into the cell and quickly confirmed to the PO that the man had died. Within a few minutes, two more paramedics arrived and, after making their own checks, they too said that he had died. Unable to do anything more for him, the paramedics left the prison.

92. In line with Prison Service procedure, the PO sealed the cell and entry was restricted and controlled. (Sealing a cell after a death in prison is normal procedure and done because the area is treated as a potential scene of crime. It remains sealed until police confirm it is not a crime scene, after which normal movement in and out can resume.)

After the man's death

93. The prison chaplain arrived to offer his support to staff and assist in any way he could. The PO said the chaplain told him that the man was of the Muslim faith and that prayers should be said over the body as soon as possible.

94. The PO asked the prison chaplain if a Muslim prisoner could be found who would agree to say prayers over the man's body. One prisoner declined, but a second offered to assist. The prisoner was taken to the man's cell and the PO opened the cell door. The prisoner stood at the entrance to the cell and said prayers, after which the cell was re-sealed.

95. After re-sealing the cell, the PO arranged for all the prisoners being monitored under the ACCT procedures to be reviewed. The purpose was to ensure that they were safe, and there was no adverse reaction to the man's death. He also arranged for Listeners to be unlocked from their cells, available, and visible to any prisoner wanting to speak to them.

96. At interview, the prison chaplain told the investigator that after prayers had been said, he made his way to the prison command suite. The reason for going to the suite was to identify the man's next of kin, as it was his intention to go and break the news to his family. However, his record was not up to date and did not have his next of kin details.

97. In the meantime, a telephone call was received into the command suite from one of the man's sisters who was enquiring about him. She had received a call that morning from her sister, who, like the man, was also in prison, and had been told that he had died. She said her sister had been telephoned by a Swaleside prisoner that morning and he told her about the death. (It would appear that the unnamed prisoner at Swaleside had used an illicit mobile telephone to make the call.) After staff confirmed that she was the man's sister, she was told that he had died.

98. As part of the support for the man's family, the Governor arranged for them to be collected from their home and taken to the prison. His family were allowed to go to his cell to see where he had lived and to spend some time in it. After seeing the cell, his family met the Governor who offered to assist with the cost of funeral arrangements.

99. The investigator has spoken to several members of staff as part of his investigation, and asked about the support available following the man's death. Without exception, they have all said the support has been good from managers, colleagues and the local care team.

100. Following the man's death, police searched his cell looking for a suicide note but without success. However, sometime later, the investigator was told by a PO that a note had been found and handed to police. The handwritten note said "I am sorry every one Sam + Mary + all Kidz I cant do this that is why I had to do this I will be with mam now. Loads + loads of love the man."

ISSUES

Healthcare at HMP Belmarsh

101. The clinical reviewer said that the reception medical screening at Belmarsh was carried out using a modified first reception health screen form. She said the form was seven pages long, with only the first page recording the prisoner's name. The doctor adds that the remaining pages could have belonged to anyone.

102. The doctor said the entries in the man's medical notes made whilst at Belmarsh were a paper record. She said they were consecutive, full and comprehensive adding that each entry was dated and signed. However, the name and designation were not printed alongside each entry. The doctor also said that many of the signatures were illegible and the handwriting was difficult to read in many of the entries.

Healthcare at HMP Swaleside

103. The clinical reviewer noted that the healthcare centre had been recently refurbished and a newly built 18 bed in patient unit with x-ray facilities, dentistry, optometry and consulting rooms for visiting doctors had opened. The doctor added that the reception area had been redesigned and the area redecorated.

104. As part of the investigation, and to understand the prison healthcare service, the clinical reviewer interviewed a number of Swaleside healthcare staff. A Registered Mental Nurse (RMN) is the Head of Healthcare. He told the doctor there had been problems recruiting general practitioners and the service had to be delivered using locum doctors.

105. The RMN said the Primary Care Trust (PCT) took responsibility for prison healthcare in 2006 and had introduced an electronic medical record. There had been some training in the use of the new system, but it was not complete.

106. The clinical reviewer said that due to the illegibility of the man's medical notes from Belmarsh, it had taken her about 30 minutes to read and extract information from them. The doctor added that, if the reception department at Swaleside was busy, it would be difficult for the nurse to read the notes properly within the time available. She makes the following recommendation, which I endorse

Consideration should be given to computerising medical records at Belmarsh or providing a legible written summary.

107. In her clinical review, the clinical reviewer said the healthcare reception screening form used at Swaleside consists of a one page document with tick boxes. This gives the author the opportunity to tick boxes if there are medical or mental health issues. The doctor said there is no flow chart which would prompt a referral if the "yes" box were ticked. Additionally, there was no way

of knowing if a referral had been made. In order to improve the quality of the information provided, and ensure that there is an audit trail for the actions taken as a result, the clinical reviewer recommends that the form is redesigned.

The Swaleside reception screening medical form should be redesigned to allow space to explain medical and mental health assessments with some indication of decisions, who has taken responsibility for referrals to further health care, and that the referrals have been made.

108. The clinical reviewer said the prison Suicide Prevention and Self Harm Management Policy has the following entry:

> "An assessment of possible risk of suicide or self-harm will be made by a member of the healthcare team on the day of reception as part of the health screening procedure for all receptions … and an ACCT plan opened if necessary. An ACCT Plan must be opened in every case where the screen is positive for current thoughts of self-harm …"

She adds that the National Institute for Clinical Excellence (NICE) Guidelines on self harm, issued in July 2004 advise that

> "All people who have self-harmed should be assessed for risk, which should include identification of the main clinical and demographic features and psychological characteristics known to be associated with risk, in particular depression, hopelessness and continuing suicidal intent. The outcome of the assessment should be communicated to other staff and organisations who become involved in the care of the service user."

109. In her clinical review, the clinical reviewer said that in the man's case, the box had been ticked to show that he had no current thoughts of self harm, so it was reasonable for an ACCT plan not to have been opened. However, there was no elaboration of his previous attempts to self harm or an assessment of his current mental state. She said it is possible that the absence of an ACCT meant that the reception nurse could assume that the risk was small, and rely on the previous prison [Belmarsh] to have already made that assessment.

110. The clinical reviewer added that since the reorganisation of healthcare at Swaleside, prison healthcare workers had become members of the National Health Service. In her clinical review, the doctor quotes from the NICE Guidelines on Self Harm which say

> "All staff that come into contact with people who self-harm need dedicated training to improve both their understanding of self-harm and the treatment and care they provide."

111. In her clinical review, the clinical reviewer said there are varying numbers of admissions into Swaleside every day. The responsibility for medical screening is shared among the nursing staff. She said training appears to be

done by observing one of the other staff completing a reception medical document. There is no requirement for a mental health assessment to be completed by a nurse with a mental health qualification, nor a requirement for new prisoners to see a doctor, unless they ask to, or are prescribed medication.

The Governor and Head of Healthcare should, in the light of the clinical review, assure themselves that health screening on reception is conducted effectively.

112. The clinical reviewer said the man's contact with healthcare at Swaleside was limited to rearranging a date for his knee operation and then reviewing his wound afterwards. She said this appears to have been done rapidly and without problems.

113. The doctor was unable to establish clear lines of responsibility for the way healthcare is run at Swaleside. She was unable to determine whether the decision to use locum doctors was policy, or a response to the inability to appoint someone permanent. The doctor said she was told that a permanent doctor was to be provided from the Sheppey Community Hospital. She stressed that the PCT should ensure that there are no further delays.

ACCT assessment in May

114. Following the man's request to speak to a Listener in May and the opening of an ACCT document, support systems were put in place. Later that same day an assessment was carried, followed by case review meeting, after which the document was closed.

115. I have considered the document carefully and am satisfied that the support systems were appropriate and actions well documented. However, the document appears to have been closed quickly. Although I can find no fault with the procedure and make no recommendation, I do wonder whether this decision was somewhat hasty. The Governor and safer custody manager will wish to satisfy themselves that ACCT documents are not closed too quickly.

Summoning urgent medical assistance

116. The use of codes to summon urgent medical assistance is common practice across the Prison Service, although it is not mandatory. Not all Governors have introduced such a system, preferring instead to allow staff to say precisely what the situation is. Unlike the majority of prisons who do use codes, Swaleside uses a four code system. The investigator spoke to several members of staff and found that the codes were not readily understood. This could cause confusion and delay in obtaining the correct medical response.

117. In this instance, no emergency call was made as the officer did not believe that anything could have been done to save the man's life. In other circumstances, however, it might make a difference. I suggest that if a code system is to be used, then it should be easy to remember and simple to use.

The Governor should review the emergency code system and, if content to continue with codes, replace it with a simpler arrangement.

Preservation of evidence

118. Following a death in custody the area where the person died is sealed and movement in and out of the area strictly controlled. This is to ensure that there is no contamination of any possible evidence.

119. In the man's case, his cell was sealed and then reopened to allow a prisoner to say prayers over his body. I have considered this issue carefully and conclude that although it was against proper procedure to reopen it without the police being present, this was done with the very best of intentions and with due regard for the man's religion. At what was a very difficult time, I believe the PO's actions were not only understandable, but decent and compassionate. Whilst I make no formal recommendation, I invite the Governor to share my comments with the PO.

Support for staff and prisoners

120. Following the man's death, all those prisoners being monitored under ACCT were reviewed, which is normal practice. At Swaleside, they went a little bit further and made Listeners available to all prisoners. The Listeners were unlocked and were visibly present around the wings. This is good practice.

121. Additionally, I have been pleased to learn of the support offered to staff. All the staff interviewed by the investigator spoke positively about the support offered to them following the man's death. The support was wide ranging, and included colleagues, the local care team and management.

CONCLUSION

122. I believe that there is no evidence to show that the man was subject to pressure from prisoners at Belmarsh to change his religion. It would appear that he did this of his own free will. Additionally, I am satisfied that he was content to transfer to Swaleside.

123. Although there was some evidence that the man was at risk when he came into prison, I judge that he was properly assessed and informed decisions taken. Equally, I am satisfied that on the second occasion when an ACCT document was opened in May 2008, he was properly assessed and following its closure, he appears to have settled in well to prison life and given no further cause for concern.

124. When prison staff discovered the man, they acted promptly to obtain assistance, whilst at the same time entering the cell to try and rescue him. As soon as they cut the ligature and placed him on the bed, the two staff realised that it was too late to attempt cardio pulmonary resuscitation. I believe from the description given that it was too late to save him and that any attempt to do so would have been inappropriate.

125. It would appear from the note found after the man died that he knew what he was doing and made his own decision to end his life. The note explains his rationale for his actions. Had he shared his troubles with prison staff I believe there would have been sufficient resources in place to help protect him. Sadly, he chose not to discuss his thoughts with anyone.

RECOMMENDATIONS

1. Consideration should be given to computerising medical records at Belmarsh or providing a legible written summary.

   The recommendation has been accepted

2. The Swaleside reception screening medical form should be redesigned to allow space to explain medical and mental health assessments with some indication of decisions, who has taken responsibility for referrals to further health care, and that the referrals have been made.

   The recommendation has been accepted

3. The Governor and Head of Healthcare should, in the light of the clinical review, assure themselves that health screening on reception is conducted effectively.

   The recommendation has been accepted

4. The Governor should review the emergency code system and, if content to continue with codes, replace it with a simpler arrangement.

   The recommendation has been accepted

GOOD PRACTICE

1. Making Listeners available on the landings following the man's death was good practice.