The circumstances surrounding the death of a man at HMP The Verne in November 2004

Report by the Prisons and Probation Ombudsman for England and Wales

August 2005

This is the report of an investigation into the circumstances of the death of a man. He was found hanging in his cell at HMP The Verne on 9 November 2004. Since 1 April 2004, the Prisons and Probation Ombudsman's office (PPO) has been responsible for investigating all deaths of prisoners in custody. During a transitional phase, which included the time of this man's death, I did not conduct all investigations directly but oversaw the work of experienced Prison Service investigators who worked under my supervision. I am most grateful to the Prison Service for agreeing those arrangements. The investigation into the man's death was carried out on my behalf by head of Operations at HMP Leyhill. He was assisted by one of my investigators.

Except for minor editing for reasons of clarity and style, I have not amended the Prison Services investigators report. I am most grateful to him for his work on my behalf.

Clinical reviews to examine this man's medical care and treatment at HMP Bristol, where he spent several months, and at HMP The Verne, were carried out by, Prison Medical Lead for South West Dorset Primary Care Trust (SWDPCT) and a, Registered Mental Nurse with SWDPCT and the National Institute for Mental Health in England.

I would like to thank the Governor of HMP The Verne, and his staff for their full co-operation with the investigation. In particular, we would like to thank the Secretariat and our Liaison Officer for responding efficiently to our requests for information.

It is hard to cope with any family loss and losing someone whilst they are in custody is especially difficult. My colleagues and I would like to extend our condolences to the man's family and to all those touched by his sad and untimely death.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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Ombudsman's summary

This man had a long history of serious mental illness. On 31 January 2004, he was remanded in custody at HMP Bristol and, because of his medical problems, he was placed in the Healthcare Centre. This was his first time in custody. Two days later, on 2 February, he self harmed by cutting his arms, and Bristol opened a suicide monitoring form (called an F2052SH). A medical assessment was conducted, and he was kept in the Healthcare Centre.

On 11 February, the F2052SH was reviewed, and it was decided that the man was fit enough to move to A wing. The F2052SH remained open. On 2 March, the man admitted that a few days earlier he had burnt his arm with a lighter. Bristol reviewed the F2052SH. It was noted that the man was refusing to take his medication and needed support to resume. The next day he said that he was having paranoid delusions and was worried that he might enter one of his schizophrenic periods. The following day he also failed to take his medication, even though he was woken up to collect it.

On 8 March, a Consultant Psychiatrist assessed the man. The psychiatrist did not think that the man's condition required in-patient psychiatric care. The man's medication was changed, and about a week later the F2052SH was reviewed and closed. A support plan was put in place.

On 30 June, staff noticed red marks around the man's neck, which suggested that he had tried to hang himself. Another F2052SH was opened. It was decided that he could remain on the wing, but that he should share a cell with someone he got along with, even though he wanted a single cell. On 8 July, a psychiatrist assessed him, and the level of observations was increased to five an hour. A review on 16 July decided to drop the level of observations back to once an hour.

On 18 July, the man's cellmate said that he was ripping up sheets to hang himself. The man was moved to the Healthcare Centre for an assessment. By 21 July he was more stable, and moved back to the wing. The F2052SH was reviewed again on 23 July, and it was decided that it should remain open, even though the man said he felt better.

On 6 August, the F2052SH was reviewed once more. There were concerns that he was again not taking his medication, and efforts were to be made to make sure that he collected it.

At a further review on 20 August it was noted that his mood was variable. He again saw a psychiatrist on 21 August. On 8 September the F2052SH was reviewed and closed.

On 9 September, the man appeared in court and was sentenced to five years in prison. On his return to Bristol he was assessed as being a category C

prisoner, and arrangements were put in train for him to transfer to another prison. The form used for the categorisation (an ICA1) has a section to complete about health problems and the level of healthcare required, but this was left blank.

The man continued to report hearing voices and feeling anxious. He also expressed concern about the length of his sentence, which had come as a surprise, and about the difficulties his symptoms were causing for his cellmate. He was therefore moved to a single cell, which he said was easier for him. On 7 October, a psychiatric review resulted in a further change to his medication, which the man reported to have improved his symptoms.

Time in The Verne

On 22 October, the man was transferred to HMP The Verne. The prisoner escort record that accompanied him said that there was no known medical risk. Little other information arrived with him, although further documentation from Bristol did arrive some time later. Luckily, in his medical reception interview the man spoke himself of his mental health problems, and he was assessed by a doctor the next day. His medication needs were sorted out, and he was to collect his medication twice a day.

The man was assessed as a high risk for cell sharing, because of his mental health problems, and put in a cell on his own. However, at The Verne prisoners have their own cell key and can move around the wings and associate with other prisoners. The man quickly made friends, and seemed to settle in. Although he spoke of his previous suicide attempts, he told his friends that he had no intention of suicide now.

On 7 November, he was given seven days medication. The decision that the man was suitable to have medication in his possession was questioned the next day at the Public Protection Meeting (which discusses all prisoners who pose a risk to the public), but confirmed. According to one of the man's friends, he said he took all the medication on the evening of 7 November to give himself a 'buzz'.

The Public Protection Meeting on 8 November also discussed whether The Verne was a suitable prison for the man. It was thought that a prison with full time medical cover might be more appropriate.

The same day, the man used the prison's sickness procedures to certify himself as unfit for work. Later that morning he had a jovial telephone conversation with a friend, and said that he hoped she would visit.

On 9 November, the man remained off work because he was sick. He told the wing office that the plug to his television was faulty. That morning he played chess with a friend, and saw the electrician who came to fix the plug. The electrician said he would return that afternoon. At midday, the man had lunch with his friends, and then said he was going to have a sleep. One of his

friends says that nothing seemed amiss. Neither prisoners nor staff saw the man alive again.

At about 3.30pm, the electrician and a prisoner visited the man's cell to complete the repair. The man was hanging from a ligature. The electrician instructed the prisoner to press the alarm bell, which he did. The electrician felt for a pulse but did not find one, and then went to meet staff responding to the alarm. He did not take the weight of the hanging body.

Staff responded within a minute, cut the ligature, and lowered the man to the floor. Healthcare staff arrived and they started CPR, helped by one of the prison officers. An ambulance was called at 3.35pm. At about 3.50pm paramedic staff arrived and started advanced life support using a defibrillator. They continued their efforts to save the mans' life until 4.20pm. A medical officer confirmed death at about 4.30pm.

The Verne made arrangements for the Governor and Chaplain of HMP Shepton Mallet to visit the man's parents to break the news, as they lived near by. The Governor and the Chaplain of The Verne also subsequently personally visited the family. Within the prison, the care team looked after staff, and officers reviewed other prisoners' open or recently closed F2052SHs. The Governor issued notices to tell staff and prisoners of the death. A staff debrief took place on 16 November. There was no hot debrief.

No medication was found in the man's cell on the day that he died. A post mortem on 16 November did not find evidence of medication in his body.

Senior Investigating Officer's report

An investigation team was formed consisting of a Senior Investigating Officer, Head of Operations at HMP Leyhill and a fatal incident investigator from the Ombudsman's Office.

Contact was made with the man's family and a visit to the family home was made by my investigator and one of my Family Liaison Officers. The family were offered, and accepted, the opportunity to contribute to the investigation.

Contact was made with the police and the Coroner's Office at an early stage of the investigation by my investigator.

A Principal Officer acted as our liaison officer and additional support was given by the staff of the Secretariat Department at HMP The Verne. The establishment provided all the necessary documentation. All personnel co-operated fully.

The establishment made contact with the parents of the man via a visit on the day of his death by the Governor and Chaplain of HMP Shepton Mallett. This was followed up by a visit by the Governor and Chaplain of HMP The Verne.

The Governor published a notice to staff and a separate notice to prisoners announcing the investigation and offering the opportunity to contribute to the investigation.

The investigation team met with local officials of the Prison Officers' Association and the Chair of the Independent Monitoring Board. Each were offered the opportunity to contribute to the investigation.

All members of staff who were interviewed were offered the opportunity to be accompanied by a Trade Union Official at interview. They were all given copies of the investigation teams Terms of Reference.

During the initial course of our enquiries we walked the site, including a visit to the cell in which the man died.

All interviews were taped and transcripts were provided to all.

The Ombudsman's Office commissioned a separate investigation into clinical issues. This was carried out by South West Dorset NHS Primary Care Trust.

We reviewed the whole of the man's prison file covering the duration of his time in custody from his first remand on 31 January 2004 to his death on 9 November 2004.

Both members of staff and prisoners were interviewed.

My investigator maintained contact with the man's family, the Coroner's Office and the police.

The Ombudsman's Office commissioned a Clinical Psychiatric Review, which was carried out by a RMN of South West Dorset Primary Care Trust.

Background about HMP The Verne

The Verne is a category C training prison for adult males on the Isle of Portland in Dorset. The original buildings date from 1873 when it was built as a citadel fortress overlooking Portland Harbour. It was taken over as a prison in 1949 using the casemates in the citadel defences for dormitory accommodation and workshops. Purpose built house blocks were constructed in the early 1970's. The prison takes a wide range of prisoners including 50 life sentence prisoners.

Accommodation – Mainly single occupancy rooms plus 72 dormitory spaces. 24-hour access to sanitation is available as all prisoners have keys to their rooms. Prisoners have freedom of movement around most of the grounds in the day time and the units at night. Prisoners on normal location are not locked in their rooms at any time.

Operational Capacity – 587.

Reception Criteria – The Verne accepts any prisoner considered suitable for its open regime, especially those serving longer sentences. The prison also acts as a national resource for holding foreign prisoners. It currently holds around 300 foreign national prisoners from more than 50 countries.

Regime – provision includes extensive industrial workshops, educational courses NVQ offered in gym, kitchen and gardens**.**

Healthcare – The Healthcare Unit is staffed by a full-time medical officer supported by three nurses, a Healthcare Manager and specialists. Prisoners requiring in-patient facilities are transferred to NHS hospitals or HMP Dorchester. Dental provision is contracted out to a local practice.

Drugs Strategy – 540 prisoners are currently on Voluntary Testing compacts and a 14-bed rehabilitation unit is in operation on B1 wing which provides a 12 step intensive programme. CARATS (Counselling, Assessment, Referral, Advice, Thoroughcare Service) support and drug awareness courses available. Positive Mandatory Drug Tests below 6%.

Chaplaincy – Full-time C of E Chaplain, part-time RC and C of E, Methodist and Muslim Ministers. Visiting Ministers of other faiths attend regularly. Multi-faith Centre in operation.

Catering – Self select menu system operates for prisoners to choose their meals. High standard. Received a Gold EHO Award in 2003.

Background about HMP Bristol

Bristol is a Category B local prison first opened in 1883. Its primary function is to serve the courts, assess and allocate sentenced prisoners to the training prison estate. Due to current overcrowding this is often done at quite short notice to create adequate space for those prisoner awaiting court appearances.

Recent years have seen an on-going programme of extensive refurbishment and renovation. The latest major project has been total refurbishment of the Healthcare facility.

Reception Criteria – HMP Bristol receives male prisoners and a limited number of Young Offenders, both convicted and remand, from all local courts as well as being a Category B facility for the West of England.

Regime – HMP Bristol places great emphasis on prisoners confronting their offending behaviour. There are courses in inter-personal skills, enhanced thinking and a focus on employment. There is also a Listeners scheme for prisoners who may be at risk from suicide or self-harm and some prisoners are employed in the prison workshops.

Accommodation – Cellular – single and double.

Operational Capacity – 606.

Events leading up to and following the death

The man was serving a sentence of five years imprisonment for the robbery of an elderly neighbour, whom he had known for four years. He was convicted at Bristol Crown Court on 30 July 2004 and sentenced on 10 September 2004. Prior to sentence he had been on remand at Bristol since 31 January 2004. He had pleaded guilty to the charges.

This was the man's first custodial sentence but he had ten previous convictions dating back to 1991.

The man had a 13-year history of intermittent psychotic episodes. According to the psychiatric report prepared by a Consultant Psychiatrist before he was sentenced, exacerbations of the man's mental health and psychosis appeared closely associated with his abuse of illicit substances. The man was also schizophrenic. He had been sectioned under the Mental Health Act on a number of occasions. Records show that he had self-harmed on at least three previous occasions prior to coming into custody. The man admitted to having a history of misuse of recreational drugs, mostly amphetamines but also cannabis and cocaine. He had a history of failing to take his prescribed medication.

On first reception at HMP Bristol on 31 January 2004, the man went through the normal reception procedures including a medical screening. It was

identified at that initial screening that he had some mental issues that needed to be addressed. He disclosed that he had suffered from schizophrenia since 1995, was taking medication for this, that he had cut his wrists six months previously and that he was not expecting to be sent to prison. He was subsequently located on the Health Care Unit.

On 2 February the man self-harmed by cutting his arms using a plastic knife. Hugh told staff that he was not suicidal but was feeling under stress. An F2052SH form was opened and he was seen by a doctor who decided that he should stay in the Health Care Centre for further assessment and support from the Mental Health Support Team (MHST). The man did not believe he should be in prison but in a hospital, a view he maintained throughout his time in prison.

On 6 February, he appeared in court. He appeared from the comments on the PER and F2052SH, relaxed and talkative. He returned to custody later that day and was located in the Healthcare Unit.

On 11 February, a F2052SH review took place and it was decided that the man was fit enough to move to A wing - as his mental state appeared to have improved - but that he should remain on the F2052SH. Comments in this document give an insight into his mood and he appeared to settle in, spending a lot of time in bed.

On 17 February, the man discussed his feelings with a member of staff prior to having a case review. Notes from that meeting state:

"No thoughts of self-harm/suicide, says it is just spontaneous, happens very quickly - his mood drops and he feels anxious and desperate. Feels claustrophobic in prison."

A F2052SH review took place later on 17 February at which it was decided to keep the F2052SH open for at least another week. It is documented that throughout this period that the man had received visits from his family, who were supporting him. He had also received support from the Mental Health Team and medication to help him relax.

On 23 February, the man described his mood as "happy" when asked and it is noted in the F2052SH that he had been in a happy mood all that afternoon.

On the review of 24 February, the man expressed his feelings as very anxious and deeply depressed, distressed and frustrated at remaining inside the prison environment. He felt that he would be better served if located in an establishment specialising in mental health.

Comments in the F2052SH up to 2 March 2004 are positive with the man in good spirits, but on 2 March, he admitted to staff that he had self-harmed the previous Sunday by burning his arm with a lighter. A review took place on this day and it was decided that he would stay on an open F2052SH as he was

refusing to take his medication and needed to be supported in order to resume.

On the evening of 3 March, the man spoke to a member of staff and stated that he was feeling a little depressed and would speak to that member of staff in the morning. They spoke the next morning, and in the conversation the man stated that he was having paranoid delusions and was becoming worried that he may enter one of his schizophrenic periods and was concerned that he might attack people. He felt staff and prisoners were against him. The officer was concerned and tried, without success, to contact a member of the Mental Health Support Team.

The man slept most of that night. He appeared quiet the next morning but his mood appeared to improve as the day went on. Contact was made with a nurse who said they would try to visit him on his residential unit. He had a visit from his family that day. The man was sad to see his mother in the prison environment. He failed to take his medication on that day also even though he was woken up to collect it.

For the next few days the man did not appear communicative or to be very happy and made references to his medication being wrong.

On 8 March, the man apologised for his behaviour and was “O.K. and back to normal”. Over the next week he had various mood swings, his medication was changed and a F2052SH review took place and the F2052SH was closed. A support plan was put in place.

Also on 8 March 2004, the man was assessed by a Consultant Psychiatrist, at the request of the man’s solicitors. The man was known to the psychiatrist and the report dated 28 April 2004 looks into the man’s mental illness, treatments and current mental state. It also states that the man’s current mental condition did not warrant transfer for inpatient psychiatric care. The man’s parents also obtained an independent psychiatric assessment of their son's mental health. I understand that its conclusions differed from the psychiatrists report and it recommended that the man be hospitalised rather than sent to prison.

Between February 2004 and 10 May 2004, attempts were made to find the man a suitable hostel should he be granted bail pending trial. A bed was found at a hostel in Birmingham but the applications for bail on both 6 May and to the Judge in Chambers on 10 May were unsuccessful.

On 30 June 2004 at 5.30pm, a member of staff noticed red marks on the man’s neck, which looked as though a ligature had been used. A F2052SH was opened and it was decided that he could be managed on normal location in a shared cell with someone who he got along with, rather than being relocated to Health Care. He does not appear to have been seen by a doctor. The man told the officer that he was prone to psychotic episodes and voices in his head. A request for the man to be seen by the MHST was made by the wing staff. A case review took after 72 hours which concluded that he had

tried to hang himself due to voices telling him to do so and he should be in a double cell for his own safety even though he wanted to be in a single cell. A support plan consisted of Samaritans and Listeners to be made available, Chaplain and Health Care Centre contact, MHST support and to stay in a double cell.

The man appeared in court on 2 July 2004 and upon return was located back on A Wing.

On the F2052SH review it was decided that the man required to be assessed by a psychiatrist. This was arranged and he saw a psychiatrist on 8 July 2004. It was also decided at that review to increase the level of observations to level 2 (five times an hour).

In the period between 8 and 16 July 2004, the man appeared to be stable. He had an issue with his canteen not appearing but this was rectified and he stated his medication had ended but this was also sorted out on the same day, 15 July 2004.

On 16 July, the man was seen by MHST for assessment. Following this a F2052SH review was carried out. It was decided at that review to reduce the observations down to level one (once an hour) and remain on open F2052SH.

On 17 July, the man complained to a member of staff that he had been threatened by another prisoner. He would not give any names or where they were located but he was told he would get hurt when he gets out. On interview with one of the Mental Health nurses on the same day, he stated that the incident was linked to something that happened prior to coming into prison. The man also stated that when he got out he would commit suicide, as it would be less painful than what had been threatened. The police were informed.

On 18 July the man was lying in bed wanting to see someone from the Mental Health Team. An officer spoke to the man's cellmate who informed the officer that he thought the man was ripping up sheets in order to hang himself. He also stated that the man had tried to cut himself with a razor. The Healthcare Unit was contacted. When seen that afternoon the man stated that he had not self harmed with a razor blade but said he was feeling anxious. He said he had not been sleeping. He was moved to the Healthcare Unit for assessment.

On 21 July, the man asked to be relocated on A Wing. He was seen by MHST. All appeared stable and the man was moved back to A Wing in shared accommodation. He spoke to a member of staff and said he was feeling better.

On the F2052SH review on 23 July, the man stated he was feeling a lot better. He felt he was ready to come off F2052SH and that he was getting on well on the wing. This was not the view of the RMN on the review who commented on the man's recent periods of unsettled behaviour and possible fluctuations in mental state.

On 30 July, the man appeared in court, pleaded guilty to the charges and was convicted but not sentenced. He returned to Bristol and was located on A Wing. There were no adverse comments from the escorting staff.

There were concerns that the man had not been taking his medication and on the review of 6 August the support plan entry states, "Ensure that [the man]collects his medication". Although he did not attend that review, he again asked to come off F2052SH. He remained on an open F2052SH as it was stated that he had only just started coming for his medication on a regular basis for the last couple of days.

On 8 August, the man stated to staff that he had not slept well the previous night and had been hearing voices telling him that he was going to get cut up. The man stated again on 18 August 2004 that voices were still taunting him and making threats towards him.

At the review on 20 August, a comment was made that the man's' moods were up and down. It was also recognised that he was due in court soon. It was also reported he would be seeing a Psychiatrist the next day, which he did.

On 8 September 2004, a F2052SH review was held. At this review it was assessed that the F2052SH should be closed. The review was made up of wing staff and Healthcare staff including a trained mental health nurse. The support plan was to continue involvement in wing regime with the possibility of a painter's job. The man had been seen by the psychiatrist and would see him again the next week. He had stated his medication had been sorted and he was happy with it and was interested in getting a job as a wing painter. He was returned to HMP Bristol and was subsequently categorised as a Category C prisoner and initially allocated to HMP Channings Wood in Devon. This initial allocation often changes as in this case due to the relative availability of spaces at Category C establishments.

On 24 September, the ICA1 form was completed by an officer. This form is used for the categorisation of sentenced adult male prisoners. It was countersigned by a Senior Officer. There is a section on page four of this form to record any healthcare issues and the level of healthcare required. There is no entry in these boxes, which there should have been. This is a systems failure and should be addressed.

On 29 September, a comment on the man's IMR stated that his mental state was stable but he was hearing voices and had delusional beliefs. He was still expressing a wish to be transferred to a psychiatric hospital.

An entry in the man's IMR dated 4 October 2004, written by a RMN, states that the man felt quite stressed and anxious. He did not expect to receive a 5-year sentence, which had increased anxiety levels. The man was concerned about his medication regime and, although getting on with his cellmate they were beginning to clash due to the spontaneous nature of the man's

symptoms. He was due to see a prison doctor on 7 October. The man was looking to engage in education or work.

On 7 October, a psychiatric review took place where his medication was reviewed and added to. Comments include that he was anxious, nervous, depressed, felt the world was against him, he burst into tears and said he could not cope.

The man was seen again on 18 October, by a member of the In-Reach Team. The man had found the increased medication helpful making it easier for him to cope with symptoms. He was now in a single cell and finding it helpful as he found masking symptoms from his cellmate stressful. He agreed to allow the in reach team to liaise with the psychiatrist regarding his current medication.

The man was transferred to The Verne on 22 October 2004. That day a prisoner escort record was prepared prior to his transfer. The Security Department identified the risk of drugs, violence, suicide and self-harm and the fact that a F2052SH had been closed on 8 September 2004. A nurse completed the medical section of the PER and had ticked the box “no known risk”. This was a fundamental mistake. The man’s IMR would have shown that he had mental health issues and was under the care of the MHIT, who should have been notified of the decision to move him. In fact they were not informed at all.

The man was transferred to The Verne on 22 October 2004. There is no written evidence that Bristol liaised with The Verne but this is not unusual. A nurse stated on interview that there may have been contact but in view of my comments above I would surmise that this probably did not happen.

On arrival at The Verne in the late afternoon of 22 October 2004, the man was seen by a Staff Nurse. On interview she could not recall seeing him but agreed that her signature was on the initial reception screen form. She also made an entry in the IMR that he should be seen by the MO (Medical Officer) the following morning, which he was. The man informed the staff nurse that he had mental health issues.

Also completed in reception was the cell risk assessment form. The man was assessed as “high risk” regarding sharing a cell. In view of this he was located in a double room on his own on B Unit. This was due to his disclosure that he had mental health issues. Normal practice at The Verne is to put new receptions into a shared cell.

Prisoners at The Verne have their own cell key and are able to move about the wings and associate with other prisoners. They are never locked in their cells.

Whilst in reception prior to moving over to B Wing, the man chatted to another prisoner with whom he became good friends.

The man was allocated room number B2-01 which was used as a double cell. He met with another prisoner who shared a cell with his friend. That cell mate also became a good friend. They would play chess, eat meals, talk and drink tea and coffee together. The prisoners said they used to look out for the man as they saw him as quite vulnerable. The man discussed his mental health issues with these friends. The man remained in this cell until he was moved to a single cell, B2-28 on 26 October. The man's friend said in interview that the man also spoke light-heartedly of his previous attempts to commit suicide, especially one incident at Bristol which failed when the shoelace he had used as a ligature stretched but he told them he had no intention of committing suicide now.

The man saw the doctor the next morning. He was to collect his medication twice daily which he did up until Sunday 7 November 2004. The first night passed with no apparent problems. This was entered in the wing occurrence book.

On 23 October 2004, an entry was made in the wing occurrence book by a Senior Officer notifying wing staff of the need to keep the man in a cell on his own. It was also recorded that the man was schizophrenic, that he had been on two open F2052SH's, and that he was to see the doctor, as he had no medication. She also entered "please monitor" and "no immediate concerns". There were no further entries in the occurrence book after that date until the death of the man.

The SO had interviewed the man as part of the reception procedures. He stated to the SO that he was fine and happy to be at The Verne. The SO commented on interview that she and the man had a perfectly normal conversation. He told her that he was suffering from schizophrenia. The SO like many others, was surprised when she learnt he had taken his own life.

On 24 October, an entry in the man's IMR says "refer psychiatry for L.V." On 27 October, The man's mother arrived at Bristol with her son's Community Mental Health worker to see him on a pre-booked visit. They were told that he had been transferred to The Verne five days previously.

On 5 November, a review of the man's medical notes was carried out. The next date for his injection was made and a referral to another psychiatrist was made. The man was aware that he would see the psychiatrist on 12 November 2004.

During the first week at The Verne, the man was involved in the induction process. He was allocated a work place in a workshop but told friends he did not have to, or want to, work as he was not employed prior to coming into prison because of his illness. The man spent the next week or so settling in, spending time with his new friends, sleeping, collecting his medication, playing chess, writing letters home and listening to music. He also had a visit from his family.

On Sunday 7 November, the man was given seven days medication in a dosage bubble pack. Also on 7 November, he applied for a visiting order for his parents to visit, which was sent out the next day.

On 8 November 2004, the man went sick using the self certificate sickness system. This allows a prisoner to remain sick for up to five days, therefore not going to work. According to a fellow prisoner, the man told him he had taken all the seven days medication on the Sunday night to get what he called a "buzz". The prisoner was quite adamant that this was not an attempt at suicide. It should be noted that no medication was found in the man's cell on the day he died except for an empty bubble-pack of tablets. There were no traces of any medication in his body at post mortem.

Later that morning, the man made a telephone call lasting just under two minutes to a female friend. He stated that the voices in his head were pretty bad but he was coping with them. This was a jovial conversation where he said in response to the question "What's it like down there?", "Oh, it's really good, it's a lot more relaxed". The friend said "You sound real happy", to which the man responded "Yes, I'm not too bad". The man asked about the baby his friend was expecting and was hoping she would visit.

Also on 8 November 2004 the monthly Public Protection Meeting was held. This is used to discuss all prisoners who pose a risk to the public and would be subject to MAPP (multi agency public protection arrangements. There was a discussion about the man and his suitability to remain at The Verne. Also discussed was his suitability for him to have medication in possession. This action was questioned at the meeting, but was justified the Mental Health Nurse. The action point was for a PO and the Mental Health Nurse to arrange for the man to be transferred out. No specific establishment was identified but it was thought that a prison with full time medical cover would be more appropriate. Transferring prisoners with medical needs was not always easy to arrange and usually took some days.

On interview with the RMN, she stated that the man was one of many at The Verne with similar issues. She added that he was happy with his medication, he had been collecting his medication regularly before he was give a week's supply and was stable while at The Verne. He had been seen, further information had arrived from Bristol and an appointment to see the psychiatrist on Friday had been made.

On Tuesday 9 November 2004, the man remained off work sick. He reported to the wing office that the plug to his TV was defective. This was reported to the Works Department at approximately 9.45 am.

At 10.00 am, the man's friend had an appointment so he did not go to work. The friend spoke to the man briefly before he went to his appointment. Upon his return, the friend went to the man's cell to collect him. The man was asleep. The friend asked the man to come and play chess. They sat down in his cell and played. Then the friend went downstairs where an officer told him that he had to go back to work. The friend went back to his cell and told the

man that he could stay in his cell but when he went back the man was not there because an officer had told the man if he was ill he had to go back to his own room, which he did.

At approximately 10.00 hours the electrician, entered the cell of the man in order to facilitate the repair of his TV socket. The electrician and officer stated that the man was lying on the bed and seemed quite relaxed. He asked what was the problem and the man said that the power had tripped out. The man also stated that the plug on his TV and the socket were not working properly. The earth plug had broken. This was put back and the electrician told the man he would be back that afternoon to change the plug and change the socket but did not give a specific time. The man had answered “fine”. The two men left closing the door behind them.

At approximately noon, the man went to lunch with his friends. They sat at the same table up to about 12.30 when they all got up, left the dining area together and went upstairs to the B2 landing. The man said to his friends, “I’m going for a kip now”. According to the friends, nothing seemed amiss. That is the last time anyone saw the man alive.

At approximately 3.30pm, the electrician and officer went to the man’s cell to complete the repair of the socket and plug.

The officer opened the door, the room was in darkness and the bed was positioned in front of the door. The officer turned the light on and saw the man hanging from the wall. He instructed the electrician to go and press the general alarm bell, which he did. The officer then said he felt for a pulse but did not find one. He stated that the man’s body was cold. .

The officer went out of the cell, pulled the door to and went to meet the staff responding to the alarm bell. At no time did the officer take the weight of the hanging body, which was suspended by a ligature made from a sheet attached to two heating pipes. He informed the staff responding about the situation. The officer then went downstairs with the electrician.

Staff responded to the alarm bell and arrived within a minute. Officers from B and C Wing entered the room together. Two officers took the weight and one cut the cord and they both lowered the man to the floor. The ligature was then cut. A gurgling sound was heard. The man was placed in the recovery position. Staff said his body felt cold.

In the meantime the Orderly Officer a PO and A/SO arrived outside the cell. The PO immediately called for an ambulance, 999 via the Control Room. Healthcare staff were called by the Control Room. The mental health nurse attended first, just after the officers had placed the man in the recovery position, followed by a Staff Nurse close behind. They had come from reception.

CPR was started and a nurse assisted by a prisoner brought the oxygen bottles to the man’s cell. A good airway was established. There was no

pulse, the man was not breathing and was unresponsive. The Healthcare staff continued with CPR assisted by an officer. All staff who attended said the man's body was quite cold.

At approximately 3.50pm, the air ambulance arrived as well as a road ambulance. Four paramedics in total took over and started advanced life support using a defibrillator which confirmed no output from the man's heart. This was at 3.58pm (as per machine printout). The paramedics continued to work on him until 4.20pm when they deemed life to be extinct. The Medical Officer who had been called in confirmed time of death at 4.30pm. The air ambulance left as did the road ambulance.

Whilst all the activity in the cell was going on, staff were clearing the landing and sealing it off in preparation for the police scenes of crime officers to attend.

The Police Liaison Officer was informed. The Coroner's Office was also informed but did not attend. National Operations Unit, Area Manager, Home Office Press Office were also notified. An SO took four photographs of the scene. The cell door was then padlocked shut. The contingency plan for a "Death in Custody" was activated.

Arrangements were made to inform the next of kin. The Governor of Shepton Mallet, and that prison's Chaplain visited the man's parents who lived nearby to break the news of their son's death.

His parents were naturally very distressed because they thought he would have been safe in prison.

At The Verne, the Care Team were looking after the staff. Some were very upset and needed someone to talk to. The Suicide Awareness Co-ordinator spoke with the officer who found the man and offered him support. The co-ordinator also reviewed all open and recently closed F2052SH's. There was no "hot debrief".

Notices to Staff and Prisoners were issued by the Governor.

At 4.57pm, the establishment was contacted by the Coroners' Office, The Coroner's officer would not be attending the prison. The police would inform the Duty Undertaker. At 5.55pm Scenes of Crimes Officers attended, supported by a Senior Officer. At approximately 7.30pm the Governor and Deputy Governor attended the scene. Police gave permission to contact the undertakers and take away the man's body. This was done quite soon afterwards.

The Governor of The Verne and the Chaplain, visited the man's parents and they were both made very welcome. They talked about the man's life, but especially his mental health history. They explained about the attempts they had made to get their son treated for his condition. They later provided the investigation team details of correspondence between themselves and the

Health Service and the complaint they had made. They were a loving, caring family who supported and visited their son regularly. An offer was made for the family to visit The Verne but they declined.

A debrief for staff took place on 16 November 2004. All aspects of the incident were discussed and those involved were given the opportunity to express their views. There were a number of apologies as not everyone could attend.

A post mortem was carried out on 16 November 2004. There were no drugs or alcohol in the man's body not even his medication (Stelazine). The cause of death was due to hanging.

The man's parents said he would show no signs of illness, but then it could appear in a short period of one to two hours. In letters home, he had written that he was happy at The Verne and was making arrangements to buy a stereo and a flask. He also said it was a good prison and was much more relaxed than Bristol. He commented on the fact that he was due to start work the next day and not looking forward to it. He wished his mum a happy birthday and apologised that he had forgotten to get a card. He told his parents not to worry as he was fine. His mother says that her son was very good at disguising his feelings from others. On the issue of him being transferred from Bristol to The Verne without her being aware, she said that the transferring prison itself should telephone a relative to make sure that they knew about a transfer rather than assuming that a prisoner had sufficient credit on a telephone card to let their family know they had been moved.

Other issues considered during the investigation

During some of the interviews both staff and prisoners raised concerns as to the suitability for The Verne to hold prisoners with mental health problems. The prison does not have 24-hour medical cover. Staff estimated there to be about 70 prisoners with varying degrees of mental illness. However, it was also acknowledged that the relaxed atmosphere and free movement of prisoners around the grounds and within the units is more favourable and therapeutic than the normal prison routine where movement and control of prisoners is restrictive and tightly managed.

Concern was also expressed by some of those at the scene that there were no defibrillators available in the prison. In the case of this man it would probably not have helped but might have assisted prison medical staff at the incident to fully assess more accurately his vital signs.

The commitment of the Governor and staff to the provision of support to the prevention of suicide and self-harm was examined. There is a suite dedicated for use to those who were at a high risk of suicide and self-harm. This was managed by the suicide co-ordinator who had been recognised by the Butler Trust for his work in this area. He was supported by a team of listeners. There were records of staff receiving training in suicide and self-harm. The HMCIP Report of 13 June 2003 praise managers and staff for excellent work

in suicide awareness. They also stated that HMP The Verne was a safe environment based on positive staff-prisoner relationships.

Clinical reviews

There were two clinical reviews on the man's medical and psychiatric care from South West Dorset Primary Care Trust. It was noted that the man suffered from schizophrenia and that his medical problems were appropriately managed. It was clear that the man was vulnerable and was afforded proper care within the limitations of the systems. Both reviews showed up that the transfer of the man was arranged without the knowledge of the Mental Health In-Reach Team at Bristol, key external workers and his family.

A further report made similar observations and added that the Mental Health provision at HMP The Verne was limited. He highlights the delay in the transfer of up to date information on the man's illness. He recommended that the meeting of prisoners' health needs should be a high priority when transfer between prisons is being considered.

Both reports highlight the record keeping which is all hand-written and has been difficult to read. Some documentation was missing and there would be benefit in an electronic system of record keeping.

Conclusions and recommendations

The man had a 13 year history of mental illness when, in January 2004, he was sent to Bristol prison. His illness was serious. He had been diagnosed as a paranoid schizophrenic, for which he received medication. He had in the past been sectioned under the Mental Health Act, and had been treated as both an in-patient and an out-patient. He also had a history of self harm, and of failure to take his medication.

While at Bristol, the man self harmed three times, and was on an open F2052SH from 2 February to early March, and again from 30 June to 8 September. My view is that the man received a good standard of care in Bristol, and that his illness and self harm problems were quickly identified and well managed. He received good support at times of crisis, and I think it fair to say that this contributed to the fact that, despite his history, the man was never violent to prisoners or staff. My only concern is whether it was appropriate to close his F2052SH the day before he was due to be sentenced.

Recommendation: I recommend that the Governor of Bristol reviews arrangements for closing F2052SHs, to ensure that full account is taken of impending sentences, and the impact this may have on the prisoner.

I am concerned, however, that the transfer to The Verne appears to have been decided without sufficient regard for the man's health, and whether the Verne would be able to meet his mental health needs. Indeed, the man's categorisation form failed even to mention his health problems at all.

Recommendation: I recommend that the Governor of Bristol should review arrangements for completing categorisation forms to ensure they are accurate, and make sure that decisions on transfers take account of the medical needs of the prisoner and the ability of the receiving prison to meet them appropriately.

I am also concerned at the lack of documentation that accompanied the man when he was transferred to The Verne. In addition, it is of serious concern that the escort record that did accompany him led to identify that his diagnosis as a paranoid schizophrenic, and his self harming behaviour, presented a risk of which The Verne should be aware. Luckily, the man told staff at The Verne of his problems. But had he not done so, not only the man himself but also other prisoners and staff could have been put at risk.

Recommendation: I recommend that the Governor of Bristol should review arrangements for completing escort forms to ensure that all relevant information is considered and included on the forms.

Recommendation: I recommend that the Governor of Bristol should also review arrangements for providing records to the receiving prison when a prisoner is transferred, to ensure that these arrive promptly in accordance with Prison Service Standards. This will ensure that the receiving prison can make appropriate decisions about the care of the new prisoner.

After the man was transferred to the Verne, he seems to have settled in and made friends. I do not consider that there were any signs that should have caused staff to think that he was at risk of suicide or self harm, and therefore that there was any reason for The Verne to open an F2052SH

However, while at Bristol, and initially at The Verne, the man appears to have had to collect his medication, rather than having it in his possession. In view of his history, both inside and outside prison, of failing to take his medication, this seems to have been an appropriate course of action. It is of some surprise, then, that on 7 November a decision was made to give the man seven days medication. It seems likely that, as a result, the man either failed to take the medication, or took it all in one go. I cannot say what impact this might have had on his state of mind, or on the subsequent course of events. But I do take the view that decisions to give vulnerable and mentally ill prisoners possession of their own medication need to be taken very carefully indeed.

Recommendation: I recommend that the Primary Care Trust in partnership with The Verne should review procedures for deciding to give prisoners possession of their medication, to make sure that they are up to the task and provide adequate protection for prisoners. Furthermore, the decision making process should be risk-assessed and clearly documented in the medical record.

The clinical reviews assessed the level of mental health provision to be insufficient. While this does not appear to have affected this man, it may be something that should be reviewed for the future.

Recommendation: I recommend that the Governor of The Verne works with Primary Care Trust providers to ensure that the level of mental health support is sufficient to meet the needs of prisoners.

When the man was first found hanging in his cell, the electrician first on the scene should have supported his body until help arrived. I appreciate that it is normally prison officers who have to deal with such emergencies, but there is the potential that any member of prison staff who is in contact with prisoners might find themselves in this position. It seems to me that all staff should receive training in what to do if they are the first on the scene in an emergency.

Recommendation: I recommend that the Governor of The Verne ensures that all prison staff who come into contact with prisoners receive training on what to do if they are first on the scene in an emergency.

I am satisfied, however, that once staff arrived on the scene, all possible efforts were made to save the man. I commend the staff for the actions that they took.

However, I am concerned that there was no "hot debrief" after the incident and a debrief did not take place until 16 November.

Recommendation: I recommend that the Governor of The Verne ensures that a "hot debrief" takes place after critical incidents.

I note that staff on the scene have expressed some concern that defibrillators were not available in the prison. Although this might not have helped the man, it may be something that the prison should consider for the future.

Recommendation: I recommend that the PCT considers whether Automatic External Defibrillators (AED) should be introduced into The Verne.

Points of good practice

The Governor and Chaplain of Shepton Mallet prison were asked to break the sad news of the man's death to his parents who lived close by. The Governor and Chaplain of The Verne followed this up by also visiting them. This is a good example of the prison taking responsibility to make sure that family were told the news as soon as possible, and by staff who were able to deal with many of their questions and concerns about their son's death.

It is also good practice that the Governor of the Verne showed his appreciation of the efforts of both staff and prisoners involved in the man's death by writing to them all personally with his thanks for their contribution.