Investigation into the circumstances surrounding the death of a man in hospital whilst a prisoner at HMP Wakefield in January 2008

Report by the Prisons and Probation Ombudsman for England and Wales

March 2010

This is the report of an investigation into the death of a man. He was a prisoner at HMP Wakefield and died at 12.57pm in January 2008 at hospital. He appears to have taken an overdose of paracetamol three days before his death. He was 34 years old.

The loss of a loved one is always distressing and I extend my condolences to the man's family. I hope that my investigation helps them to better understand the circumstances surrounding his death. I must also apologise for the delay in issuing this report.

The investigation was carried out by my colleagues. A clinical review was commissioned from the local Primary Care Trust and this was completed by a clinical reviewer with the assistance of a pharmacist. I would like to thank them for their observations and recommendations.

I am also grateful to the then Governor of HMP Wakefield and her staff for their co-operation and assistance during this investigation. Particular thanks go to the most efficient liaison officer.

The man was a troubled young man who, 15 years into a life sentence, was still having difficulty coming to terms with the enormity of his offence. In my reports, I do not usually go into great detail about the offences leading to imprisonment. However, in this case his offence and his reaction to it was relevant to his state of mind at the time of his death. He had also recently been told that he had multiple sclerosis, a progressively debilitating illness that would make him increasingly dependent on others. His mobility and general physical health was deteriorating and he had taken the decision to give up a job he loved.

I make five recommendations to the Governor, the majority of which relate to the assessment and support given to prisoners who might be at increased risk of self-harm. I have also commented on the support given to disabled prisoners at HMP Wakefield. Most significantly, the report draws attention to Wakefield's former practice of allowing prisoners up to eight paracetamol tablets at a time, without keeping any record. This practice was reversed during the course of the investigation. Given the evident dangers of even modest quantities of paracetamol and the capacity for stockpiling, it is to be hoped that this practice is not in place in any other jail.

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.

Stephen Shaw CBE
Prisons and Probation Ombudsman **March 2010**

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SUMMARY

The man died in hospital at 12.57pm in January 2008. He had told staff at HMP Wakefield at 9.44pm on 4 January that he had taken an overdose of 40 paracetamol tablets 24 hours earlier. He was 34 years old.

In 1991, when the man was 18 years old, he was sentenced to life imprisonment. He had no previous convictions. He was categorised as a category A prisoner (a prisoner who would be highly dangerous to the public, police or national security if they were to escape) and remained so until his death.

The man was a quiet man who found social situations difficult. He did not mix with many other prisoners and had a small group of friends. He was assessed as being unable to deal with negative emotions, and found it very difficult to come to terms with his offence. He did agree to attend an offence related treatment programme in 1998, but had difficulty in demonstrating any empathy with his victims. During the course, he also disclosed new information about his offending and was assessed as being at a higher risk of offending at the end of the course (which he was advised to repeat). This assessment marked a turning point for him. He refused to participate in the sentence planning process thereafter, in the belief that he would never be released from prison.

Throughout his time in custody, the man had periodic bouts of depression. This was particularly so in the winter months, when he would engage in non life-threatening self-harm. He was prescribed anti-depressant medication to help control his mood swings.

The man had worked in the Braille Unit at Wakefield for approximately ten years and was very highly thought of by the instructional staff. He loved this work and was committed to the unit. He trained others, and had designed a bespoke computer programme to improve the transcribing process.

In October 2000, the man started to complain of pins and needles in his legs, but the sensation soon stopped and was put down to a muscle strain. In November 2002, he complained of paraesthesia (an unusual tingling or burning sensation on the skin) down his leg, muscle numbness and problems with his eyesight. He was referred for tests but refused to attend external hospital appointments. An X-ray showed no abnormality.

He continued to complain periodically of paraesthesia and problems with his vision. He was diagnosed with a vitamin B12 deficiency in September 2006 and prescribed injections which seemed to help his sight. He continued to refuse to attend hospital appointments until he saw a Consultant Neurologist in May 2007 when the possibility of multiple sclerosis was first discussed. He then realised that he needed to accept medical help, and in July 2007 agreed to attend appointments and take all prescribed medication.

The diagnosis of multiple sclerosis was confirmed in August, by which time the man was already having problems with walking. He was described by Wakefield's Disability Liaison Officer as being "frail and unsteady on his feet".

At the end of June 2007, the man was moved from C wing to D wing as a result of a hole being discovered in his cell. He was also put onto the Escape list which meant increased security precautions whenever he left the wing. He found this change very unsettling and he initially struggled to make new friends.

During the second half of 2007, his health deteriorated and he was provided with the use of a wheelchair to get to work. The use of the wheelchair caused considerable confrontation and upset with staff. He tried to commandeer the chair for his sole use, but it was eventually withdrawn in December on medical advice.

Also in December, the man decided that he was physically unable to carry on working in the Braille Unit. He requested and was given medical retirement. Staff and prisoners who knew him, including his psychiatrist, all said that he gave no indication of any intention to take his own life.

On the evening of 4 January 2008, the man pushed a note under his door and rang his cell bell. The note said that he had taken 40 paracetamol tablets 24 hours previously, was in a lot of abdominal pain, and had been sick.

The night officer immediately summoned assistance and the man was assessed by a nurse. The nurse took advice from the 24 hour helpline at the Poisons Unit. They said that the prescribed medication that he was taking would heighten the effect of the paracetamol, and that the vomiting could be a sign of liver failure. An ambulance was called and he was very quickly escorted to hospital. He slipped into a coma the next day and died. His family saw him before he went into the coma and were with him when he died.

The toxicology report says that the level of paracetamol in the man's blood was 16.4 mg which, if not treated within 24 hours, is potentially a fatal overdose.

I make five recommendations and recognise the quick and professional response of the nurse. I also comment on Wakefield's then policy that wing staff could give prisoners eight paracetamol tablets at a time on request, with no record being kept.

THE INVESTIGATION PROCESS

1. Two investigators carried out this investigation on my behalf. The first investigator made initial contact with the then Governor of HMP Wakefield and formally opened the investigation on 15 January 2008. She met the Governor and the then Chair of the Independent Monitoring Board and a representative of the local branch of the Prison Officers' Association. She also visited the man's cell on D wing and the healthcare centre.

2. All available documents likely to be required for the investigation were collected or requested at this time. During the course of the investigation, the investigator kept the incoming Governor informed of progress.

3. Notices were issued to staff and prisoners. The notices announced the investigation and invited anyone who had information about the man's death to make themselves known to either investigator.

4. My investigators visited the prison on 1, 2 and 3 April. They conducted six interviews with relevant prison staff and three with prisoners who knew the man. This report is based on these interviews and a review of all relevant paperwork including the man's clinical records.

5. The incoming Chair of the Independent Monitoring Board (IMB) asked to be interviewed. During the interview, he raised concerns regarding the procedure for secondary dispensing at Wakefield. My investigators considered his evidence. However, as it concerned the dispensing of prescribed medication, it was considered to be outside the terms of reference for this investigation and therefore not included in my report.

6. The clinical reviewer and his assistant were nominated by the local Primary Care Trust to conduct a clinical review of the medical care the man received whilst in custody. The review team interviewed the nurse at Wakefield on 16 April. They shared their initial findings with senior members of the healthcare team at Wakefield on 22 May 2008.

7. My investigator contacted HM Coroner to inform him of the nature and scope of this investigation and to request a copy of the post mortem report. Upon completion, a copy of this report will be sent to the Coroner to assist in his enquiries.

8. One of my Family Liaison Officers contacted the man's mother and father to inform them of my investigation and offer them the opportunity to raise any concerns that they wished us to address. The man's father raised two matters. The first concerned the issue of medication. The second was whether the stomach pain the man complained of could have been a symptom of a problem with his arteries (the post mortem report identified severe clogging of the arteries). The issue of medication is addressed within my report. The post mortem report clearly records that the cause of the man's death was paracetamol poisoning, and therefore the cause of stomach pain falls outside the scope of this investigation.

9. A copy of the draft report, including the clinical review, will be sent to the family once completed. I hope that my investigation has helped them to better understand the circumstances leading up to the man's death.

HMP WAKEFIELD

10. HMP Wakefield is a high security prison for men. It is one of eight high security prisons in England and Wales and has a centre for life sentenced prisoners. In its current form, the prison dates back to 1845 and the wings are arranged in the Victorian-style radial system. The prison can accommodate approximately 700 prisoners, including a maximum of 100 category A prisoners (prisoners who would be highly dangerous to the public, police or national security if they were to escape) and ten high risk category A prisoners.

11. There are four accommodation wings, A, B, C and D, all built on four levels. All cells are single occupancy, each wing has shower and cooking facilities for the prisoners and there are snooker and pool tables for recreation. D wing has 183 cells over the four levels. At the time of the man's death, there were 25 category A prisoners living on the wing. Each landing has three officers during the day and each wing has one officer during the night time.

12. HMP Wakefield provides 24 hour nursing care and has a 20 bed inpatient facility. Primary care is provided by the local Primary Care Trust and a mental health in reach service is contracted to the Mental Health Trust.

13. The prison's Independent Monitoring Board's report for 2007/2008 "acknowledges the good work being done in all departments of the prison." In particular, it refers to the improvements being made in the healthcare department. It highlights a number of areas of concern, none of which is relevant to the man's death.

14. HM Chief Inspector of Prisons carried out an unannounced inspection of Wakefield in 2005. She concluded that:

    "Overall, Wakefield was clearly a prison on the move."

15. There were five deaths in custody at Wakefield in the eight months preceding the man's death. Four were as a result of natural causes and one was apparently self-inflicted.

KEY FINDINGS

16. The man was sentenced to two life sentences on 25 October 1992. He had been convicted of the murder of a woman known to him and the murder and rape of a child. He was given a tariff of 25 years. (A tariff is the minimum period a life sentence prisoner has to serve in custody.) This was reduced to 20 years in 2000. His first parole review was due in March 2008. He was classified as a category A prisoner and remained so throughout his time in prison.

17. The man was 18 years old when he first entered custody, and had no previous convictions. A Social Enquiry Report (now known as a Pre Sentence Report) prepared by the Probation Service described him as quiet, withdrawn and leading a chaotic lifestyle. He was prone to violent outbursts and had problems communicating, made worse by a speech impediment. The early documentation also records that he took an overdose while in the police cells shortly after his arrest. However, interviews with forensic psychiatrists at the time of his conviction did not identify any mental illness.

18. His prison records document a second self-harm attempt by the man in 1991. He was noted as being withdrawn and uncommunicative, but had shown some improvement by the time he was transferred to HMP Wakefield in December 1994 when he was 21. There were further recorded instances of superficial self-harm in 1994, 1998, March and May 2005, and in January 2006.

19. It is clear from prison records that the man was not a problem for prison staff. Although he was quiet, he would challenge decisions that he thought were wrong but did so politely and usually following the complaints procedure. He did not mix with many other prisoners, keeping himself to himself and having a small group of friends. He would not volunteer information to staff but would answer questions if asked. His mother and father kept in regular contact with him and offered considerable support.

20. The man started work in the Braille Unit in December 1997 and excelled as a transcriber, often teaching new prisoners the required skills. He worked within this unit until he retired on medical grounds in 2007. His work was highly praised by the officer who runs the unit.

21. Early in his sentence, the man had been assessed as needing to attend the Sex Offender Treatment Programme (SOTP). SOTP is a cognitive behavioural programme made up of 210 hours of group work, designed to identify and address distortions in the thinking process. Prisoners are risk assessed at the beginning and the end of the programme to measure any change in their risk of re-offending. He completed the programme in August 1998 but had some difficulties in addressing some of the victim awareness issues and in demonstrating empathy towards his victims. He also disclosed new information with regard to his offending. As a result, the tutors assessed his risk of re-offending to have increased at the end of the programme and recommended that he should repeat it.

22. The man reacted with anger and extreme frustration to this recommendation, and from 1999 refused to discuss his offence or engage in the sentence planning process at all. (Sentence planning is the process by which relevant staff across the prison and the external probation officer meet with prisoners to agree targets to reduce the risk of re-offending.) He refused to attend these meetings or any meetings with staff to discuss his progress.

23. According to prison records, the man converted to Buddhism in September 2000. No reason is documented for this conversion but it was formally approved by the chaplaincy.

24. At a Life Sentence Planning Board in December 2001, the man's external probation officer suggested that he had come to the conclusion that he would never be released and therefore did not need to undertake any offending behaviour work. This view was documented by the man himself in a letter to another probation officer in 2000 and again in a complaint form in 2005.

25. In 2003, a trainee forensic psychologist reviewed the man's assessment reports. She concluded that he needed help in problem-solving and dealing with negative emotions, in particular those that would result from addressing the issues around his offending. She recommended that he attend a Stress Management course and the Enhanced Thinking Skills programme.

26. The man maintained regular contact with his mother and father until 2005, when he decided that he did not want any external contact at all. He also self-harmed on two occasions during this year, burning his arm with a cigarette and scratching "nonce" and "retard" into his arm. He was placed for a week on monitoring under the provisions of a F2052SH self-harm document to ensure closer observation and support from staff. (The F2052SH process has since been replaced by the Assessment, Care in Custody and Teamwork (ACCT) procedures.)

27. He refused to participate in the sentence planning process until 2006, when he attended the Stress Management Course. However, he still refused to attend the sentence planning meetings. He then agreed to be assessed by a second trainee forensic psychologist. Following this interview, the man wrote to her complaining of a breach of confidentiality and said that he would not communicate with the Care Management Team in future.

28. In the past, the man had been reluctant to seek mental health support but had admitted to low moods during the winter for which he had been prescribed Sertraline, an anti-depressant. He sought further help with his condition and was assessed by a nurse from the mental health in-reach team on 10 October 2006. A Threshold Assessment Grid (a way of assessing the severity of a person's mental health problems) was completed. His score did not give cause for concern. However, he was referred to a Consultant Forensic Psychiatrist, at his request, for support in coping with a possible seasonal affective disorder (low mood in winter months).

29. The Consultant Forensic Psychiatrist first saw the man six days later and he remained under his care until the time of his death. The psychiatrist noted that

during the time he worked with him, “His mood was stable and I had no major concerns about his mental state … He never gave any signs of suicidal intent.”

30. The man first complained of pins and needles in the back of his legs on 16 October 2000. This was thought to be the result of a strain doing yoga exercises and the sensation was recorded as having cleared at a follow up appointment a week later. He next complained of paraesthesia (an unusual tingling or burning sensation on the skin) down his leg, muscle numbness, and problems with his eyesight, in November 2002. He was referred for X-rays and to an optician. The X-rays showed no abnormality and he refused to attend the eye clinic or go to any outside hospital appointments.

31. The next recorded mention of paraesthesia was in November 2005. X-rays and blood tests were normal, but the man continued to experience sensations in his legs and he was referred to a neurologist on 30 March 2006. He was diagnosed with a vitamin B12 deficiency - which can cause pins and needles and problems with vision - for which he was prescribed vitamin B12 injections. Six months later, his medical notes record an improvement in his vision.

32. A consultant neurologist examined the man in November 2006 and requested an MRI scan. He again refused to attend hospital for appointments until 22 May 2007. He then had an appointment with the neurologist, who first raised the possibility of him having multiple sclerosis (MS) and requested further tests. The man was recorded as saying that he did not want to discuss any diagnosis until it had been confirmed. However, he appears to have realised that he now needed to accept medical help. On 3 July, he wrote a letter to say that he would no longer refuse hospital appointments as he had in the past and would take all prescribed medication. Six days later, he wrote another letter detailing his symptoms. Neither of these letters has an addressee, and it is not possible to say which, if any, staff read them.

33. The diagnosis of MS was confirmed on 17 August by the Specialist Registrar in Neurology following the results of a lumbar puncture. The man had another appointment at hospital on 1 October 2007 to discuss options for steroids and disease-modifying drugs. At this appointment he also raised a problem with urinary incontinence.

34. Prison records show that staff started to notice a deterioration in the man’s physical health around June 2007. He was having trouble walking and requested help in collecting his meals. An entry by the Disability Liaison Officer describes him as “frail and unsteady on his feet”.

35. On 26 June 2007, during a routine search, staff discovered a hole in the wall of the man’s cell around the sink area. It was decided to place him on the Escape list (E list) and move him from C to D wing. As an E list prisoner, he was required to wear distinctive clothing whenever he left his wing and he was subject to greater staff supervision.

36. The man’s friend on C wing told my investigator that the man had denied any thoughts of escape. He claimed that the hole was a result of recent

refurbishment, and that a number of other cells on the wing had the same holes. As someone who found making friends difficult, the man was very upset by the change to his routine and location. He was removed from the E list on 15 August 2007 but remained on D wing.

37. A disability file was opened for him but the date was not recorded. A Senior Officer was responsible for overseeing support for disabled prisoners. In early July, she told him that he could use a wheelchair if he needed to go any distance off the wing, particularly to his job in the Braille Unit. Prison Service Order 2855 "Prisoners with Disabilities", paragraph 6.8, says:

> "Any form of aid to mobility (or to sensory perception) including wheelchairs, whether specially adapted or not, crutches, sticks etc need to be retained in possession, unless there is a good (and defensible) reason not to. If Reception staff are concerned that there may be a security risk involved, a risk assessment needs to be carried out and a suitable alternative provided."

The PSO also requires in paragraph 6.31:

> "All prisons will normally have in place contingency plans for dealing with fires that take account of persons with individual/special needs. (Taken from Standard 18 Fire Safety). The PEEP (Personal Emergency Evacuation Plan) should be drawn up for every prisoner who may need assistance in the event of an evacuation. Wing and activities staff should be aware of any prisoner who might need assistance in the case of an emergency."

The PEEP in the man's file has not been completed.

38. The use of the wheelchair appears to have caused considerable conflict between the man and wing staff. He was waiting to be measured for his own chair. In the meantime, the wheelchair was a wing resource to be used by any prisoner who needed it. However, he took possession of the chair, taking it into his cell and even making a laminated sign for it stating that it was his property. Over the next few months, he made little effort to walk at all and was becoming reliant on the wheelchair.

39. The man wrote to the then Governor in September 2007 outlining the problems he was experiencing in collecting his meals, cleaning his cell and using the laundry. This letter was referred to the SO for a response. She went to see him to give him information about the Disability Liaison Officer (DLO) on his wing. The entry by her does not deal specifically with the practical issues raised by him nor does it authorise a carer to assist him. (A carer is a prisoner who is paid to help a disabled prisoner.) During interview, another category A prisoner said that he took on this role from July 2007, but my investigator was unable to establish when this had been formally sanctioned.

40. The man's solicitors wrote on his behalf to the Governor on 26 November 2007, seeking clarification on whether prisoners could keep wheelchairs in their cells on

D wing. The Governor wrote in reply, “I am informed that the man has no difficulty in accessing any part of the wing regime. He is able to collect his meals and associates freely on the wing”.

41. In late December, after a number of confrontations, the DLO withdrew the wheelchair from the man, advising him that he needed to use his legs as much as possible to keep them active. This action was taken on the advice of the Consultant Neurologist. The man was also told it was unwise to “borrow” equipment that had been measured for someone else. However, he could still use the wheelchair for longer distances.

42. At the same time, the man requested and was granted medical retirement from the Braille Unit. His health was deteriorating and he was no longer able to type with both hands due to numbness in his fingers and dizziness. The Braille Unit officer tried to dissuade him, advising that they could find him alternative work to keep him occupied. He recognised that the man had loved his job in the Braille Unit and thought that he was likely to deteriorate further if he had nothing to focus on. The response was that he would read and watch television.

43. The man’s personal officer remembered the man asking him on 3 January 2008 to check whether anyone had been in touch about measuring him for his wheelchair. He described the man as “very calm”, “not agitated or depressed …To me, he didn’t give any signs that he was going to take his life.”

44. On the afternoon of 4 January, the man’s carer went to his cell to fill a flask with water for him. He saw the man being sick in the sink, but thought he just had an upset stomach. Later that evening, the man was in the cell of another prisoner, playing Triominoes. The prisoner said that the man had vomited, bringing up blood. He advised him to ask to see healthcare staff but he refused. The prisoner said in interview that he informed a wing officer. My investigator was unable to establish if this took place and, if so, the identity of the officer. The prisoner said that, apart from the vomiting, the man was cheerful and had been his usual self that evening.

45. Prisoners are locked in their cells for the night at 7.00pm on weekdays. The wing is patrolled through the night by one officer whose shift officially starts at 8.30pm. However, most night staff come in early and leave early by mutual agreement with the day staff. On the evening of 4 January, the night officer on D wing carried out the required checks on all prisoners and began his usual night routines.

46. The cell call bell register shows that the man rang his cell bell at 9.44pm and the night officer responded 40 seconds later. He opened the viewing hatch, looked in and saw the man sitting on his bed. He asked if he was alright but he did not respond. The night officer then noticed a piece of paper that had been pushed under the cell door. It was a note from the man saying that he was in need of medical attention. It said that he had not eaten a proper meal in 2/3 weeks, and that he had been vomiting for last 24 hours and was in chronic abdominal pain. The last paragraph said, “I have taken an overdose of approx 40 paracetamol

tablets about 24 hrs ago." At that time, wing staff could give prisoners eight paracetamol tablets at a time on request and no record was kept of the issue.

47. The night officer immediately went to advise the Principal Officer, who was in charge of the prison. He then telephoned the healthcare centre and asked for the duty nurse to attend. As the man was a category A prisoner, three prison officers, a senior prison officer, and a dog handler, were all required prior to unlocking his cell at night. The staff assembled very quickly. While waiting to be escorted to D wing, the nurse checked the computer system and identified the medication the man was taking.

48. The nurse arrived on the unit about ten minutes later and assessed the man. She noted that there was evidence of vomiting in his cell toilet. She knew that 40 tablets was potentially a fatal dose of paracetamol and rang the national 24 hour helpline at the Poisons Unit for advice. Having told the Poisons Unit that he was taking prescribed carbamazepine (an anti-convulsant and mood stabilising drug), she was advised that this would heighten the effect of the paracetamol and that the vomiting could be a sign of liver failure.

49. An ambulance was called at 10.27pm and arrived at the prison at 10.33pm. The ambulance left the prison at 11.02pm and the man arrived at hospital at 11.15pm.

50. The man's condition deteriorated. The handcuffs were removed at the request of the doctor and he was moved to the Intensive Care Unit. The prison's Buddhist Minister visited him. When asked why he had taken the tablets, he is recorded as saying he felt down at the time.

51. The prison contacted the man's parents and his mother, father, stepmother, sister and brother-in-law all visited the following day. His mother, father and stepmother were with him most of the day and night.

52. I have been surprised to learn that an officer was sent by a Governor to carry out an Assessment, Care in Custody and Teamwork (ACCT) assessment for the man's on the morning of 6 January.

53. The man slipped into a drug induced coma and was placed on a life support machine. Following attempts to resuscitate him, he was pronounced dead at 12.57pm on 6 January 2008. His father and stepmother were with him when he died.

54. The Governor advised all staff and prisoners of the man's passing and offered support to anyone who felt they needed it.

55. The toxicology report confirmed that the level of paracetamol in the man's body was 16.4mg. This is potentially a fatal overdose if not treated within 24 hours.

56. The prison's Family Liaison Officer made contact with the man's mother and father. They both attended a memorial service held in the prison chapel on 11 February and had an opportunity to speak with the Governor. After the memorial

service, the man’s friends from the Braille Unit sent letters of condolence and a translated book to the family.

ISSUES

Medical care

57. In his clinical review the clinical reviewer identifies five areas of good practice operating within the primary care services provided at Wakefield. However, the man's medical care was hampered on many occasions by his refusal to attend hospital appointments. Multiple sclerosis is a disease that is difficult to diagnose. The symptoms are unpredictable and vary from person to person, and there can also be periods of remission when symptoms appear to subside. The clinical reviewer is satisfied that, when the man complained of paraesthesia, appropriate investigations were undertaken.

58. With regard to the man's mental health, several psychiatrists who assessed him came to the conclusion that he was not suffering from mental illness. He was a quiet and withdrawn individual with a history of periodic self-harm which was not linked to any intention to take his life. He often refused support that was offered to him at these times. In later years, as his physical health deteriorated, he appeared to be more accepting of help. He had agreed to see a psychiatrist who remained responsible for his mental healthcare until his death. The psychiatrist said that the man never gave any indication of suicidal intent. He also recognised that, "a history of previous self-harm and coping with a disabling physical condition would increase the risk of suicide but there was no indication from my interviews with him".

59. The practice at Wakefield at the time was that wing staff were allowed to issue eight paracetamol tablets at a time to any prisoner who asked for them without having to make a record. This is likely to have contributed to the amount of paracetamol that the man was presumably able to stockpile and thus to take. This practice – which, given the known dangers of paracetamol overdose, I am bound to say I think was mistaken and lax – ceased during the course of my investigation. I am pleased that this action has been taken. Paracetamol can now only be obtained from the nurse during the regular issue of medication.

Significant events

60. From my investigation, it seems that the man found it very difficult to even think about the offences he had committed. In the assessment report following his completion of the SOTP, he was said to have admitted that he blocked his emotions because he felt he could not cope with experiencing them and might take his own life if he did. He evidently found the SOTP extremely difficult emotionally. Being told that he would have to repeat this process triggered the withdrawal from all contact with the sentence planning process. He seemed to accept that he would spend the rest of his life in prison.

61. It is also clear that the man did not make friends easily. He was a quiet man who kept himself very much to himself. Having spent seven years on the same wing, the transfer from C to D wing must have been very unsettling. He was also located on to the third landing. This meant going up and down stairs which was already becoming a problem for him because of the onset of multiple sclerosis. I

do not doubt that staff had good reason to transfer him if they believed he was trying to escape. Security considerations are rightly paramount in the case of any category A prisoner. However, a review of the documentation and his need for peer support might have merited relocation back to C wing once he had been removed from the E list. I also judge that location on the third landing was not appropriate in the circumstances.

The Governor should review the process for allocating cells to ensure that medical restrictions are taken into account within the constraints of security.

62. The use of the wheelchair became a bone of contention between the man and prison staff. It is clear from his disability file that the wheelchair had been offered to help him when he had to travel some distance, in particular to get to the Braille Unit. It was never intended for his sole use. However, this seems to be against the spirit of the guidance in PSO 2855, "Prisoners with Disabilities" when it says that aids to mobility should be retained in possession. In any event, he commandeered the wheelchair and, as a result, it was not available for communal use on several occasions. Subsequently, he was still allowed to use the wheelchair: but only for longer journeys, not to get around the wing.

63. It is evident from the documentation and interviews that the man was starting to have severe mobility problems. His personal officer said "he would literally have to hold onto things to walk." It is unclear from the documentation whether a referral was made to the NHS for him to be assessed and measured for his own wheelchair. However there are entries on the wing file that suggest this was necessary. If this is accurate, and he was considered in need of a wheelchair, the withdrawal of the chair without providing any substitute walking aid could have affected his quality of life considerably. In hindsight, given the diagnosis of MS, it seems to me that this matter could have been handled with greater sensitivity.

The Governor should ensure that staff adhere to the requirements of PSO 2855, "Prisoners with Disabilities".

64. The man's inability to cope with negative emotions is further evidenced by his not wishing to be told about a possible diagnosis of multiple sclerosis until it was confirmed. He constantly refused to attend hospital appointments – in the hope, perhaps, that it might go away. Once the diagnosis of multiple sclerosis was confirmed, there is no evidence of any counselling being offered to him or any consideration of activation of the ACCT process. Had this been considered, he would have received greater support to come to terms with the diagnosis.

The Governor should advise staff that, when a prisoner is informed of a progressive illness, they should consider whether it is appropriate to activate ACCT support. This consideration should be clearly recorded in the prisoner's medical file.

65. The letter the man sent to the then Governor in September 2007, in which he outlined the problems he was having with practical everyday living on D wing,

was a cry for help. My investigator was provided with a copy of his disability file. Information in it showed that staff clearly had tried to advise him and provide him with information. However, there is a distinct lack of practical help recorded. It is also disappointing to note the Governor's response to the man's solicitors in November. His staff had obviously not researched the man's situation with any rigour prior to briefing the Governor to advise the solicitors that he "has no difficulty accessing any part of the wing regime".

66. The final significant event prior to the man's death was his decision to seek medical retirement. It is clear that he was committed to his work in the Braille Unit. As a young man still facing many years in custody, this must have been a very difficult decision for him to make. The request was approved by healthcare staff, but again there does not appear to have been any consideration given to providing him with additional support. In fact, the disability file simply notes that the wheelchair was removed the next day.

The Governor should advise staff to consider what additional emotional support is required whenever a long term prisoner is medically retired before retirement age.

The Governor should ensure that the disability officer agrees and monitors an action plan with the prisoner outlining how they will occupy their time constructively.

The night of 4 January

67. Taking into account the significant events outlined above and the man's previous attempts at self-harm, it is possible that he took the paracetamol as a cry for help, rather than as a determined attempt to take his own life. All staff and prisoners who knew him and who were interviewed for my investigation were shocked and surprised by his death. His personal officer who saw him on 3 January (the day the man apparently took the paracetamol) said, "To me he didn't give any signs that he was going to take his life." The second prisoner, who was with the man on the evening of the 4 January, said that "he'd been his usual self". The man's carer, said he was "flabbergasted" when he heard. It seems that no one who knew the man had thought he would take his own life.

68. The fact that the man pushed a note under his door asking for help may also suggest that he did not intend to die. We do not know if he knew the effect that the paracetamol would have when combined with his other medication, or the time period after which the dose would be fatal. We do know that he had a history of non life-threatening self-harm when feeling down.

69. The nurse's response to the emergency was timely and professional. She managed to elicit important information regarding the man's medication prior to being taken to D wing. She quickly completed her assessment, checking his physical condition and offering reassurance. She confirmed her findings with the Poisons Unit, and was able to provide them with all the required information to inform the decision of immediate transfer to hospital. Her quick and professional approach is to be commended.

70. The instruction by a Governor for an officer to conduct an ACCT assessment with the man on the morning of 6 January was plainly unnecessary and inappropriate. Sending an officer to conduct an assessment at this time could have been seen as insensitive by both the man's family and by bedwatch staff. I am surprised that the Governor was not aware of feedback from escort staff at the hospital that the man was in a coma and unlikely to survive. A simple phone call could have avoided this happening.

CONCLUSION

71. During his long time in prison, the man had difficulty coming to terms with his offences. He was a quiet man who found it hard to make friends, and he was not comfortable in social situations. He had a tendency to harm himself – it seems as a release rather than as a serious attempt to take his own life – when he was feeling down. He seems to have accepted that he would never be released from prison.

72. The man had recently been told that he had a progressively debilitating illness which would make him increasingly dependent on others. His mobility was deteriorating and he had taken the decision to give up a job he loved. He was unable to move around the wing easily, and the wheelchair that he had latched onto as a way of maintaining some independence had been taken away, albeit temporarily.

73. These circumstances would no doubt have made him feel "down" and may have contributed to his decision to take an overdose of paracetamol. Whether this was intended to end his life or to focus attention on his situation cannot be known.

74. Wakefield's then practice of providing prisoners with up to eight paracetamol tablets without keeping a record may have assisted the man in stockpiling the number of pills he was to take. I think this former practice was most unwise, and have been pleased to learn that a new policy has been put in place during the course of this investigation. This has meant that I have had no need to make a formal recommendation. Nevertheless, the NOMS Safer Custody and Offender Policy Group and Offender Health will wish to consider if guidance should be offered to all prisons given the evident dangers presented by even relatively modest quantities of paracetamol.

RECOMMENDATIONS

1. The Governor should review the process for allocating cells to ensure that medical restrictions are taken into account within the constraints of security.

   This recommendation was accepted. The response was:

   "Medical prognosis/diagnosis made by Doctor/medical staff/Physio. Relayed to relevant managers/ Disability Co-ordinator for reasonable adjustments to be made within constraints of security. Allocated Accordingly."

2. The Governor should ensure that staff adhere to the requirements of PSO 2855, "Prisoners with Disabilities".

   This recommendation was accepted. The response was:

   "Requirement of all staff to be familiar with PSO 2855 'Prisoner with disabilities'. To be included as part of the SPDR [appraisal] process for this year. Disability Liaison Advisors are available on each wing to offer advice and support to staff and prisoners.

   "Circulated to SMT (20/04/2009) to devolve into staff SPDRs 2009 to 2010."

3. The Governor should advise staff that, when a prisoner is informed of a progressive illness, they should consider whether it is appropriate to activate ACCT support. This consideration should be clearly recorded in the prisoner's medical file.

   The response was:

   "The above recommendation implies that ACCT should have been activated to provide long-term support to someone who is suffering from a progressive medical condition. Palliative care should have been provided, but not, I would suggest, under the auspices of ACCT.

   The description of ACCT below does mention long-term needs but this is meant in relation to situations such as repetitive self-harm.

   ACCT is a care-planning system whereby staff can work together to provide individual care and support to prisoners identified as being at-risk of suicide/self-harm in order to:

   - *Help defuse a potentially suicidal crisis or*
   - *Help individuals with long-term needs (such as those with a pattern of repetitive self-injury) to better manage and reduce their distress."*

   Paragraph 68 has been amended to clarify that the aim of the recommendation is to provide support to prisoners to help them come to terms with a diagnosis, rather than suggesting that ACCT is used as part of the long term medical

support.

4. The Governor should advise staff to consider what additional emotional support is required whenever a long term prisoner is medically retired before retirement age.

   This recommendation was accepted. The response was:

   "A review of the current procedures around the medical retirement of Offenders will be completed. This will also look at what additional support needs to be provided to those offenders who have already been medically retired."

5. The Governor should ensure that the disability officer agrees and monitors an action plan with the prisoner outlining how they will occupy their time constructively.

   This recommendation was accepted. The response was:

   "Multi Disciplinary Meeting established to ensure that a prisoner notified of a progressive illness is supported and constructively occupied. Members of this meeting will include:

   - *Prisoner*
   - *Disability co-ordinator –DLA (Disability Liaison Advisor.)*
   - *Member of medical Team Doctor/ Nurse/ Mental Health Team/Physio*
   - *Prisoners Case Officer or designated Nurse (dependant on location.)*
   - *Representative from Prisoners Activity Area.*
   - *Manager from prisoner's residential unit.*

   The action plan generated at this meeting will be actively managed by the Case Officer or Nurse responsible for the prisoner. Advice and support will be available from any of the above named staff in supporting the member of staff managing the action Plan."

Good Practice

The nurse's quick and professional approach to the emergency when the man revealed he had taken an overdose of paracetamol is to be commended.