PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man at HMP Garth on 25 January 2010

Report by the Prisons and Probation Ombudsman for England and Wales

October 2010

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A man was found at just after 8.00am in his cell at HMP Garth, having covered his head with a plastic bag and suffocated during the night of 24 and 25 January 2010. He was found on the morning of his birthday. I offer my sincere sympathy and condolences to those touched by his death.

The investigation was carried out on my behalf by two of my colleagues. A clinical review of the man's healthcare is being undertaken on behalf of Central Lancashire Primary Care Trust. Unfortunately, the review is not yet available but I have decided to issue my report without it. I would like to thank the Governor of Garth and her staff for their co-operation and assistance. Particular thanks go to the Acting Deputy Governor for his help throughout the investigation.

The man came into prison late in life, having been convicted of a murder committed almost 30 years before. He was in HMP Manchester for two years before transferring to Garth in 2007. The man did not talk freely with many officers or prisoners but he only very rarely contravened prison discipline. He worked on the gardens party and largely kept himself to himself. He had regular visits, through the pastoral visits scheme, from a longstanding pastor in the community. The visits were terminated by the prison (although the pastor could still visit under the normal visiting arrangements) shortly before the man took his life.

Although the man was subject to suicide and self-harm management monitoring procedures twice in 2008, there was no clear indication that he was preparing to take his own life in early 2010. Staff responded quickly when he was found but he had died during the night. I judge that the man's death could not have been reasonably predicted. There is some evidence that he planned his own death, but I am satisfied that he did so in a way that did not draw him to the attention of staff or prisoners.

I make three recommendations in this report regarding pastoral visits and family liaison issues. However, the recommendations are complemented by a number of learning points, some of which the prison brought to the attention of the investigators, and had already been addressed.

Jane Webb
Acting Prisons and Probation Ombudsman **October 2010**

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SUMMARY

The man was born in 1944. He worked as a school teacher in the north of England. He was convicted and sentenced to life imprisonment in 2005. The man was sent initially to HMP Manchester, where he told staff that he was upset about his conviction. During his time at Manchester, the man was visited by a pastor from a church in Manchester who had befriended him during his trial. The visits were conducted under the pastoral visits system, when a religious leader can meet a prisoner in a confidential setting.

The man transferred to HMP Garth in September 2007. He told staff that he was worried about being in prison, but did not want any support from the mental health team. The pastor continued to visit the man at Garth until early 2008 when the prison told him that they were withdrawing the visits. The pastor complained and the visits resumed in April 2008.

Suicide and self-harm monitoring procedures were put in place in July 2008 when prison staff realised that the man had been sent documents relating to the custody and suicide of another prisoner. The man was adamant that it was unnecessary as he was not going to harm himself. The procedures were ended later that month.

In late November, the man's appeal against his conviction was rejected. He reacted by complaining of feeling ill and vomiting. Other prisoners came forward to staff concerned that he might harm himself. Suicide and self-harm monitoring procedures were put in place again the following day and the man was moved into the healthcare centre. The monitoring procedures were ended in mid-December.

The man did not often come to the attention of staff in 2009. He worked in the gardens party and attended education classes. In December, the prison again ended the pastoral visits the man had previously enjoyed. The pastor complained but they had not been reinstated before the man's death.

Following the man's death, it became clear that he had given away a number of items to other prisoners in the days leading up to death. Neither the man's friends nor officers were aware of this. On the morning of 25 January 2010, staff unlocked the cells as usual at approximately 8.00am. The prisoner in the cell next to the man was aware that he usually left his cell straight away to telephone his wife. When the man did not appear, the prisoner went into the cell and found him on his bed with a plastic bag over his head and a cord around his neck. Prison and healthcare staff attended but the man had already died.

The prison telephoned the man's wife to break the news and the chaplain visited her later that day. Unfortunately, an offer of a contribution to the funeral expenses was not made to the man's wife although I understand that this has been rectified. My report contains three recommendations regarding pastoral visits and liaison with the man's wife.

THE INVESTIGATION PROCESS

1. A colleague led the investigation assisted by another colleague. On their initial visit to the prison, my two colleagues met the Governor and Deputy Governor. They were also introduced to the Chairman of the Prison Officer's Association local branch. My colleagues were shown the F wing and the man's cell. Notices were issued to prisoners and staff to alert them to the investigation. No-one came forward in response to the notices.

2. My colleague wrote to Central Lancashire Primary Care Trust to request a review of the clinical care the man received while in prison custody. The clinical reviewer, who conducted the clinical review, was provided with all of the relevant documentation and transcripts of the interviews in order to assist in her report. The clinical review has been delayed and, as the man had little interaction with healthcare staff, I have decided to publish my draft report without it. The final report will contain the findings of the clinical review.

3. The office's Senior Family Liaison Officer contacted the man's family to discuss the investigation and any concerns they had. The family raised the following issues:

    - They were concerned that the man was being verbally abused by other prisoners while undertaking the gardening duty.
    - The man did not receive a hat that was sent in to him.
    - They were concerned that the man was ridiculed by prison officers for wearing several layers of clothing when the weather was cold.
    - They wanted the ending of the man's pastoral visits to be investigated.
    - The man's wife said that she was unhappy about the manner in which she was told of her husband's death.
    - The man's wife said that she was unhappy about the way in which her husband's property was returned to her.

4. The investigators conducted interviews with five prison staff and two prisoners on 3 February 2010. The investigators returned to Garth on 6 May to meet with the clinical reviewer and prison family liaison officer. They also fed back the interim findings of the investigation to the Governor. Two further interviews were conducted over the telephone with prison staff. They are included with the final report in order to allow the interviewees the chance to review them. The investigators also corresponded with the National Offender Management Service headquarters chaplaincy team regarding the issue of pastoral visits.

5. The National Offender Management Service and the man's family commented on the draft report, and I have included responses to their comments in this report.

HMP GARTH

6. Garth is a category B training prison which was opened in October 1988. The prison can hold 847 prisoners, and generally has approximately 550 prisoners subject to indeterminate sentences for public protection (IPP) or life sentences. On 25 January 2010, there were 835 prisoners in the prison.

Pastoral visits

7. Prison Service Order (PSO) 4550 (Religion manual) states:

> "Prisoners are entitled to special visits from their local clergy or religious leader.
> - One individual should be nominated, and security clearance obtained in each case.
> - Where there is uncertainty about the standing of any individual within their own faith, advice should be sought from Chaplaincy HQ or Religious Consultative Services.
> - Visits should be supervised to take account of the need for privacy and confidentiality.
> - Such visits should be in accordance with local procedures and at intervals deemed by all parties to be reasonable. In the event of disagreement, the Governor, in consultation with Chaplaincy HQ if necessary, will decide what is reasonable."

8. Pastoral visits are different from ordinary visits due to their private and confidential setting, away from other visitors. The frequency of ordinary visit is explained in PSO 4410 (Prisoner communication – visits) which says:

> "Governors may organise visiting arrangements to accommodate the particular needs of the establishment and the wishes expressed by prisoners and visitors, subject to the following provisions:
> a) Each unconvicted prisoner must be allowed visits on at least three days a week, including the opportunity for a visit on Saturday or Sunday, normally every weekend and at least once a fortnight;
> b) Convicted prisoners, both adult and young offenders, should be allowed a visit on reception after conviction and at least every two weeks thereafter, including at least one weekend visit every four weeks."

9. Prisoners can gain extra visits as privileges under the Incentives and Earned Privileges scheme. Prisoners at the standard level receive two privilege visiting orders per month, enhanced prisoners receive three privilege visiting orders per month.

Personal officers

10. Each prisoner is assigned a personal officer who acts as the officer that they can turn to should they need help. The officer is also required to have regular conversations with the prisoner and record these interactions.

Assessment, Care in Custody and Teamwork (ACCT)

11. Assessment, Care in Custody and Teamwork (ACCT) is a care planning tool used by the Prison Service to help support and monitor those prisoners identified as being at risk of suicide or self harm. The ACCT process encourages staff to work together to provide individual care to prisoners in distress and help to diffuse circumstances where self harm or suicide may occur.

Listeners

12. A Listener is a prisoner trained by the Samaritans to provide emotional support to other prisoners. It is a confidential service which provides support but not counselling.

Independent Monitoring Board

13. Each prison has an Independent Monitoring Board (IMB) made up of members of the community. The Board's role is to ensure that the prison is properly run and that prisoners are treated decently. Each Board produces an annual report for the Secretary of State. The most recent report available from the Garth IMB is that of December 2008 to November 2009. The report stated that the prison is providing a safe environment where prisoners are treated with decency and respect and have, currently, access to an extensive programme of education and skills. The Board noted the increase in incidents of self-harm but considered that the prison took the issue of safer custody seriously.

Her Majesty's Chief Inspector of Prisons

14. Her Majesty's Chief Inspector of Prisons conducted an announced inspection of Garth from 30 March to 3 April 2009. The report noted the difficulties caused by the sudden increase in IPP prisoners but said that they "found Garth to be one of the most effective and well-run adult prisons we have inspected". The report described the range of education and work as 'outstanding' and praise the collaboration between departments to meet the needs of prisoners. Incidents of self-harm were reported to have increased, but the suicide prevention strategies were described as effective.

Previous deaths at HMP Garth

15. The death of the man is the only self-inflicted death that Garth has experienced since the Ombudsman's office began investigating deaths in custody in April 2004. However, one prisoner died from natural causes in 2009, and two more have died from natural causes in 2010.

KEY FINDINGS

16. The man was convicted of murder in 2005, and sentenced to life imprisonment with a minimum tariff of 15 years. Upon his arrival at HMP Manchester he told staff that he was "gutted" about his conviction, but said that he would not deliberately harm himself. On 2 February, a post-conviction immediate needs assessment was carried out. The man told staff that he had begun to have thoughts of harming himself, but he would not act on them as he needed to "stay strong" for his family.

17. The man saw a doctor on 19 March. He complained of heart palpitations and lower back pain. The man explained that he had a history of irregular heart beats and it was decided to undertake an electro-cardiogram (ECG). He went to the healthcare unit on 27 March in order for this to be conducted.

18. During his time at Manchester, the man was visited by a pastor from an evangelical church in the Manchester area, who had befriended him during his trial. These meetings were conducted under the pastoral visits system.

19. On 12 September 2007, the man transferred to HMP Garth. His family history of heart trouble was noted, as was the absence of self-harm or suicide attempts. It was noted that he was anxious and depressed due to being in prison, but he said he was coping and did not wish to see the mental health team.

20. However, the man did see the mental health team two weeks later on 28 September following a referral from the reception staff. He stated again that, although anxious about being in prison, he did not intend to harm himself. He said that he did not want any support from the mental health team, although they did discuss the option of counselling.

21. The pastor visited the man at the end of November. This was arranged through the pastoral visits scheme. He arranged a further visit for December but, when he arrived, he was refused access to the prison. The pastor said that the prison mentioned concerns about security. In early 2008, the pastor received a letter from the prison saying that they had decided to stop the pastoral visits because they were able to fulfil the man's spiritual needs within the prison. The pastor questioned Garth's decision and asked them to reconsider. The visits resumed in April. The man was given leave to appeal against his conviction on 30 April.

22. Staff began the Assessment, Care in Custody and Teamwork suicide and self-harm monitoring procedures on 23 July. This was in response to the man being sent documents in the mail relating to the self-inflicted death of a prisoner. The document was the Ombudsman's anonymised report into the prisoner's death which is published on the office's website. The man denied that the documents increased the risk of him harming himself but the staff were sufficiently concerned to begin ACCT procedures.

23. Staff included details of the material in security information reports (SIRs). The sections of the report included details of the method the prisoner used to end his life, as well as quotes from the prisoner's journal explaining his determination to hide his plans to commit suicide and information about the number of prisoners who committed suicide on their birthdays. I understand that when the documents were removed from his cell, staff said that the man told them something to the effect of "I know what I need to know now."

24. The ACCT plan required staff to have a "meaningful conversation" with the man at least once every morning, afternoon and evening. These are supportive interactions when the member of staff talks with the prisoner. Senior Officer A was his ACCT case manager and recalled the man's comments at the time:

> "And he was in constant denial that he was going to do anything, he wasn't particularly talkative to anybody. … he just basically said that that was between him and his wife and no one else, and it had nothing to do with anyone else. It was basically nobody else's business."

25. The following day, a multi-disciplinary meeting was held to discuss the care of the man. Staff were concerned that he was planning to harm himself, but he repeatedly denied having any suicidal ideas. The man continued to be monitored and, on 29 July, it was decided to close the ACCT. A post-closure review was held on 24 September. The man stated that the ACCT had been unnecessary as he had not intended to harm himself. Unusually, a further post-closure review was held on 21 November. The man was described as feeling positive, and looking forward to his appeal. It was also noted that he was aware of the support available should he need it.

26. The man's appeal was rejected on 27 November. He was described as withdrawing into himself and complained of feeling ill and constant vomiting. Other prisoners came forward to staff to express concerns that he might harm himself as he was seen giving items away to other prisoners. (Giving away personal items has sometimes indicated that someone is planning to commit suicide.) ACCT procedures were begun the following day, and the man was admitted to the healthcare unit on 29 November, where he was subject to the constant watch procedures. (This is when a member of staff observes the prisoner at all times. It is used when staff consider a prisoner to be at a very high risk of harming themselves.) The man was unhappy about moving to healthcare and said he had no intentions of taking his own life.

27. Staff noted that he had thrown out a lot of belongings from his cell but the man explained that he had just been clearing it out. He said that he was in shock following the failure of his appeal. The man was taken off constant observation on 1 December, and intermittent observations were put in place. On 4 December, during an ACCT review, the man said that, although he did not need to be in the healthcare unit, he did not mind staying there for a while. It was agreed that he would return to a normal wing the following Monday.

28. The man returned to his cell on F Wing on 8 December and appeared happier having returned to normal location. The investigators were told by Officer A, the man's personal officer, that the man had moved to cell 30 at this point. His previous cell was in the middle of the wing and the man had been disturbed by the noise from the pool table. Cell 30 is close to the servery and, other than at mealtimes, is in a quieter area of the wing. Cell 30 was one of several safer cells on F wing. (A safer cell is specifically designed to reduce the opportunity for someone to harm themselves. It has, for example, reduced ligature points.) However, the man was not placed in that particular cell for the purpose of safety. Had an at-risk prisoner needed it, the man could have been moved to a different cell to accommodate them.

29. The ACCT was closed on 15 December. Staff wrote that he had suffered a great shock with the failure of his appeal, but had now recovered. A post-closure review was held a week later and the same impression was noted. The man said that he now wished his case to be heard by the Criminal Cases Review Commission, and would continue to fight to clear his name.

30. On 29 January 2009, the man was found guilty of attempting to pass an envelope to a visitor the previous day. The prison were unable to tell the investigators what was in the envelope. I understand that the visitor was the pastor, the pastoral visitor. The security information report (SIR) regarding this incident said that the pastoral visits should be withdrawn, and the pastor should be written to informing him of this. It is unclear whether the letter was sent, but the visits appear to have continued until December 2009.

31. The man worked in the prison gardens from March 2008 until his death. The leader of the team that the man worked on told the investigators that the working hours were 8.45am to 11.45am and 1.50pm to 4.30pm. He said that the man enjoyed working outdoors and, although quiet, got on well with the other prisoners. The leader of the team didn't think there was any bullying or intimidation on the gardens party and said he never saw the man being abused by other prisoners. He worked part-time in the gardens so that he could undertake IT courses and qualifications in the mornings.

32. On 16 December, Officer B telephoned the pastor to tell him that his pastoral visits were being ended. It appears that the visits had taken place fairly regularly each month. The pastor did not receive the message and arrived at the prison the following day for the visit. He was allowed in but told that such visits were no longer possible as the legal visits area, where they took place, was becoming full.

33. The pastor wrote to the prison requesting a change in decision. Governor A, Head of Security and Operations, replied explaining that the visits were being stopped because the prison was capable of meeting the man's spiritual needs. The decision had been reached in collaboration with the chaplaincy team who noted that the man went to the chapel regularly and took a full part in their meetings and discussions. The pastor was told that he could continue to visit the man, through a normal visiting order, in the main visits area. The pastor continued to dispute this decision up to the man's death. He was

adamant that he did not want the man to have to sacrifice a visiting order so that he could visit him.

34. On one of days prior to his death, the man became involved in an argument with another prisoner in the servery queue. Apparently, the man had inadvertently bumped into another prisoner who began to verbally abuse him. The investigators were told that this prisoner then became abusive to the other prisoners and staff in the vicinity. One of the prisoners the investigators spoke to said that the man was troubled by this altercation. However, he did not raise it with his personal officer, and his friend, Mr A, did not tell the investigators that the man seemed concerned. Rather, Mr A recollected that he had told the man that he had friends on the wing. The man replied that he realised this because of the number of prisoners who defended him during the altercation.

35. The man gave away some personal items in the days leading up to 25 January 2010, but none of the prisoners involved raised the issue with staff. Following his death, the prisoners said that they did not associate this behaviour with the risk of the man harming himself. Mr A said that he seemed to give the items away to people who would not raise any concerns, and, if asked, the man had plausible explanations for what he had done. Mr A said that if he had known about it he would have been concerned about the man's welfare.

36. During his interview with the investigators, Officer C said that the man did nothing that attracted staff's attention and had carried on in his usual manner in the days leading up to 25 January.

37. The man spoke to Reverend A, a member of the chaplaincy team, on 21 January. Reverend A explained to the investigators that he was from a free church background. There is national agreement from a number of denominations to meet the pastoral needs of all free church Christians. The chaplain saw the man frequently as the man regularly attended the chapel. The man had asked Reverend A if he knew that his pastoral visits had been cancelled. Reverend A confirmed that he knew the visits had been stopped. He told the man that he believed it was connected to the man having, in the past, attempted to pass mail to the pastor. The man was unhappy about the decision, and warned Reverend A that he would bring "bad publicity" to the prison. The chaplain told the investigators that he was aware that, when the man was at HMP Manchester, protests had been conducted by his supporters outside the prison. He thought that this was the type of bad publicity the man was referring to. He did not consider that it referred to the man harming himself.

25 January

38. On 25 January, the man's birthday, the regular early morning roll check was completed at approximately 6.00am. (A roll check involves counting the prisoners to ensure that the correct number is in the prison.) The officer completing this check saw the man in his bed, apparently asleep.

39. Officer C and his colleague, Officer D, began unlocking the cells on F wing at approximately 8.00am. Officer C told the investigators that staff typically unbolt the doors of the cells, without going in to wake each prisoner. Officer D began with cell F1-30, the man's cell, while Officer C proceeded with the rest of the cells. Officer C described his reaction to not seeing the man:

> "[The man was] Usually unlocked first, he came down and used the phone, he phoned his wife every morning. He wasn't there, so I recall thinking well I wonder where he is, strange him not being there."

40. Mr A, who occupied the cell next door to the man, was also aware that he was generally already up and dressed when the doors were unlocked. Mr A was so surprised to not see the man that he went into his cell. He found the man in his bed, with the covers pulled over his head. He had a plastic bag over his head with a cord tied around his neck.

41. Mr A left the cell and alerted Officer C. The officer went into the cell and checked the man. The officer told the investigator that, in his opinion, the man was dead as his body was beginning to stiffen, and his appearance was waxen. Mr A had told him that the man had no detectable pulse. The cord around the man's neck was not immediately removed. Officer C told the investigators:

> "However in my own opinion, there was no life to preserve, it was clearly evident that the man was deceased and had been for some time. In my opinion, rigor mortis had set in. … it would have been a futile attempt to try and administer any form of CPR [cardio-pulmonary resuscitation]."

42. Mr A was taken from the wing and placed in a cell with a Listener on G wing. Officer C left the cell and told Senior Officer (SO) A about the man. The officer telephoned the communications room and the healthcare unit to ask for their assistance. Senior Officer A went into the cell. He too judged that the man was dead. He used the urgent message signal to alert the control room and healthcare unit to the situation by radio. (Senior Officer A told the investigators that he did so to ensure that the message was properly received and understood, not because he thought the man could have been saved. He agreed with Officer C that the man's life could not have been saved.) Nevertheless there was a delay calling the ambulance as communications staff were not clear that it was necessary because the man was already dead.

43. Nurse A was alerted by radio to the situation and went to the man's cell at approximately 8.12am. He asked the communications room to alert the healthcare member of staff carrying the radio 'Hotel 2' to come to the man's cell with the emergency bag, as he did not know what they would be dealing with. (Hotel 2 is the call sign assigned to a radio held by a member of the healthcare team.) Nurse A cut the cord around the man's neck and moved the bag to one side. Newspaper was covering the man's mouth which was

also removed. Nurse A performed a series of checks but concluded that there were no signs of life. He told the investigators:

> "We checked for a carotid and radial pulse and then I asked for a stethoscope to check for the apex pulse. It was at that point that there was no obvious signs of life. The man's chest was extremely hard, his limbs were contracted and I asked my colleagues to double check for a pulse. … There was no life to preserve unfortunately. His pallor was very waxy, he was tepid and there was evidence of levidity [the pooling of blood in the lowest parts of the body after death] within his limbs as well, which would explain or indicate that death had taken place quite a while ago."

44. At 8.45am, the pastoral visitor telephoned the prison on behalf of the man's wife who was expecting her husband's usual morning telephone call. The man's wife lives about two hours drive from the prison. As a result of the call, and due to fears about the news reaching her by some other way, Deputy Governor B decided unusually that the news of her husband's death should be broken to her by telephone. (Recommended practice is that the prison should break the news in person.) Governor B is a trained family liaison officer (FLO) and was asked to do this.

45. Reverend A suggested that Governor B might not be the best choice to be the family liaison officer given his correspondence regarding the pastoral visits. Reverend A was asked to be the FLO. He visited the man's wife later that day. Contrary to the Prison Service Order, an offer to contribute to the funeral expenses was not made. The man's wife telephoned Deputy Governor B later that afternoon to discuss her immediate concerns. Reverend A, the FLO, later visited the man's wife and returned all of the man's property to her.

46. Following the man's death, Deputy Governor B wrote a letter in reply to the pastor's MP to apologise for the confusion over the visits, and to offer an explanation to the pastor.

Support for prisoners and staff

47. Officer C explained that support was offered to the prisoners. Counselling and the mental health in-reach team was offered to Mr A, and the others involved in the events of 25 January. Any prisoners subject to suicide and self-harm monitoring procedures were also re-assessed to ensure their well-being.

48. After finding the man, the staff care and welfare team were immediately deployed to support staff. A hot debrief was held at approximately 10.30am in the boardroom. It was chaired by Deputy Governor B and included all those involved in the events of the morning. A critical incident de-brief was held on 15 February. These meetings allowed staff to review the response and express their views on it.

ISSUES

Whether the man was at risk?

49. The man had been subject to ACCT monitoring procedures on two separate occasions in 2008. The first was begun due to the correspondence he had received and the second was when he gave away items following the failure of his appeal. In the first of these instances the man had documents that concerned staff as they referred to the suicide of another prisoner. Staff were concerned and I believe that they acted appropriately in beginning the ACCT procedures.

50. The documents referred to the fact that the other prisoner died on his birthday. The man took his own life on his birthday. Significant anniversaries can increase the risk of suicide and self-harm. However, it is difficult to know what dates are significant to the person concerned. Research undertaken by the Prison Service indicates that there is a slightly increased risk of a self-inflicted death in the week before and of the birthday. However the findings reveal that the overall proportion of self-inflicted deaths in which birthdays appear to be a major factor is low and may be explained by random variation. This research was included in the Ombudsman's report into the death of another prisoner that the man had in his possession in 2008.

51. Although the documents read by the man could suggest an element of planning, given that he had not attempted to harm himself on previous birthdays, I do not think it reasonable for staff to have acted differently, particularly in the absence of any other obvious risk factors. The most recent of the ACCT procedures was closed in December 2008 and I consider both to have been appropriately managed and closed.

52. With regard to the man's actions immediately prior to his death, reports emerged that he had been giving away items in the days leading up to 25 January. Officer C explained to the investigators that one of the prisoners given items did question the man, but he convinced him that there was nothing to worry about.

53. This account was confirmed by another prisoner who told the investigators that the man had given him some packets of crisps in the days before his death. The prisoner did not find this unusual and did not alert officers about it. The man's personal officer told the investigators that he had not known that he had been giving away his belongings.

54. Mr A, the prisoner who found the man, told the investigators that he had not known he was giving his things away, and would have told officers if he had done. I am satisfied that staff were not aware of what the man was doing. If they had known, I hope that they would have recognised that it could indicate his intention to end his life.

55. Other than giving away his belongings (which staff were not aware of) the man does not appear to shown any concerns in the period leading up to his

death. The officers and prisoners who knew him said there was no change in his demeanour. The leader of the gardens party confirmed that he was unaware of any changes in the man's attitude or behaviour. Reverend A, from the chaplaincy department, saw the man regularly and said that he wasn't concerned about the man's welfare. Although the man had been involved in a brief altercation with another prisoner in the days leading up to his death, his friends and the officers told the investigators that he did not consider this to have been a cause of great distress to him. There was also nothing in the man's paperwork to suggest that it greatly concerned him.

56. When there are no apparent warning signs, it is very hard for staff to put in place strategies to safeguard prisoners. I do not think that the staff could realistically have predicted that the man would take his life. I believe that his death was neither predictable nor preventable.

57. The man's family responded to the draft report by saying that, in their view, the reasons for the man's death were clear, and listed a number of factors as follows:

> "1) His pastoral support was withdrawn
> 2) A hat which he requested twice was denied to him twice.
> 3) It was the coldest and longest winter in a long time.
> 4) He suffered from the cold as he was 65 years old and didn't carry any body fat.
> 5) Exposure to cold over long periods causes depression
> 6) It was the anniversary of his conviction.
> 7) It was his birthday.
> 8) It was just after Christmas.
> 9) It was in the depths of winter.
> 10) Vindictive behaviour from certain prison staff.
> 11) A bullying incident from another prisoner."

58. I have investigated whether there were signs that the man was intending to end his life but there is no clear evidence why the man acted as he did. Of course, the man's family may be correct in the reasons they list but I must limit myself to what evidence the investigation has established. The man dissembled his intentions and did not give clear signs that he would take his life. With regard to the potential significance of the timing of the man's actions, it is impossible to know if this was a factor but the man had been in prison for several years and previous significant dates had passed without incident.

59. The prison has a responsibility to support those prisoners who they have reason to believe are at risk of harming themselves. They did not judge the man to fit into this category and therefore did not begin ACCT procedures. I do not criticise the prison in this regard due to the lack of clear signs that the man was at risk of harming himself.

Using a plastic bag

60. The man used a plastic bag to end his life. A plastic bag is something that prisoners are ordinarily allowed to keep in their possession. It was, I understand, used to line the rubbish bins in the cells. Staff would not routinely remove objects from prisoners unless they had a specific reason to do so. They did not take things from the man as they did not consider him to be at risk of harming himself. Even if staff had considered him to be at risk the plastic bag might have remained in his cell. PSO 2700 (Suicide prevention and self-harm management) states:

> "However, removing personal belongings from a person who is feeling hopeless and depressed … can increase feelings of distress and therefore increase the risk of suicide, self-harm or a higher risk method of self-harm. Where possible, prisoners at risk should be allowed to retain their belongings unless it is clearly unsafe to do so."

61. I am satisfied that it was appropriate for the man to have the bag which is a routine item in a prisoner's possession. He was not judged to be at risk and there was no reason to suspect that he would use it to end his life. Following the publication of the draft report, the man's family commented that they were surprised that a vulnerable prisoner had access to a plastic bag. It is important to note that because the man was not deemed to be vulnerable, his access to items normally in his possession was unrestricted. As pointed out above, even had the man been deemed to be at risk it is not certain that the bag would have been removed from his cell.

Ending the pastoral visits

62. The man had been visited by a pastor from a local church during his time at Manchester prison under the pastoral visits procedure. After the man moved to Garth, the visits were ended, and then restarted. Garth again decided to stop the visits in December 2009, and they had not resumed prior to the man's death.

63. Prison Service Order (PSO) 4550 (Religion manual) provides an opportunity for the prisoner's local clergy or religious leader to meet them in private. The PSO does not lay down restrictions to these visits other than the visitor must be security cleared and the visits should be conducted in accordance to local procedures. This part of the PSO was included, according to the chaplaincy team at the National Offender Management Service, to allow prisoners to maintain links with their local faith groups to aid their resettlement after release.

64. Garth stopped the visits twice and engaged in a long correspondence with the pastor about them. The pastor said that the prison intimated that they were concerned about the security of the visits. The prison became further concerned when the man was seen attempting to pass an envelope to the pastor during a visit. The SIR recommended that the pastoral visits entitlement should be withdrawn. However, nothing appears to have been

done until December, almost a year later. Although a security concern would have been an appropriate reason to end the entitlement, it was not stated as the reason why the prison wished to stop the visits in the letters to the pastor.

65. Instead, Garth used the man's full and regular use of the prison's chaplaincy team as a reason to end the visits. While it is clear that the man did regularly attend the chapel and did not claim that the chaplaincy team were unable to meet his spiritual needs, this justification is irrelevant according to the PSO.

66. The decision to end the visits was a decision for Garth and, as noted, there are several grounds for pastoral visits to end. However, the prison did not use criteria set out in the PSO to make their decision. I have found that the issue was not clearly handled by Garth as the visits were allowed, stopped, allowed again before finally being stopped. Communication with the pastor was also unhelpful as the responses often failed to answer the pastor's questions. I am pleased to hear that the Deputy Governor has written to the pastor's MP offering an apology for the tone of the correspondence. The Deputy Governor has also offered to meet the pastor to explain the decisions taken by the prison. This apology and offer is to be welcomed, although too late to benefit the man. Nevertheless, the prison should consider how it would react to a similar situation in the future.

The Governor should consider PSO 4550 and ensure that decisions are consistent and clearly explained to prisoners and their faith leaders.

67. I understand that the headquarters chaplaincy team are available to help on such matters, should they be required.

68. The man's family responded to this section of the draft report by requesting greater investigation into the details of the decision-making regarding the ending of the pastoral visits. It is clear from their response that this issue has caused the family a great deal of distress. However, I must distinguish between the early incidents and communication and the final ending of the pastoral visits. Although the report acknowledges the early decision making and communication was flawed, the details of these early incidents fall outside the remit of our investigation as they are not immediately relevant to the death of the man.

69. The man's family stated that they considered the ending of the pastoral visits to be crucially important to understanding why he chose to take his life. The only recorded evidence I have seen that the man was troubled by the issue was on 21 January 2010 when he told Reverend A that he would bring bad publicity onto the prison for ending the visits. Reverend A did not view this as an indication that the man would harm himself, and I consider his response to be understandable. There is no evidence of the man becoming upset on any other occasion, threatening to harm himself or raising the issue with his personal officer. My investigators have seen no evidence that the man at any other point during his entire time at Garth complained about the issue of pastoral visits at all.

70. The man's friends on the wings consistently said that the man did not appear troubled in the days leading up to his death, and did not mention anything regarding pastoral visits to the investigators. It is impossible to know what was on the man's mind at the time of his death. As there were no recorded signs that the decision greatly upset him, I cannot be sure that the ending of pastoral visits was an explicit reason for his death.

Clinical care

71. The man had very little significant contact with healthcare staff whilst he was in prison, other than the time in healthcare following the first ACCT procedures in 2008. The clinical reviewer described his overall medical history in prison:

> "The Clinical Review has highlighted that the man was generally in good health and maintained his fitness by regular exercise. A health screen conducted on reception to HMP Garth revealed that the man had personal or family history of cardiac disease, asthma, hearing difficulties and lower back pain. He received appropriate further investigation and treatment and maintained his own stock of medication. The man was reluctant to acknowledge any signs of distress or accept mental health care."

72. With regard to the man's decision to take his life, the clinical reviewer wrote:

> "In concluding the Clinical Review, I concur with the findings of the Draft Report of the Investigation into the man's death that the man's death could not have been reasonably predicted."

73. Although there were no healthcare issues while the man was alive, two issues were identified regarding the emergency response to his death.

Calling the ambulance

74. When the man was found, the officers and nurses agreed that the man had died and there was no life to preserve. They did not attempt cardio-pulmonary resuscitation (CPR) and I am satisfied that this was appropriate. This is consistent with Annex 13A of PSO 2700 (Suicide prevention and self-harm management) which states:

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

75. An ambulance was requested but it did not arrive for some time. Nurse A told the investigators that he asked on a number of occasions where the ambulance was and was told that it was on its way. The investigators were told that the delay calling the ambulance may have been caused by a lack of certainty over whether it was necessary given the consensus that there was no chance of reviving the man.

76. I am satisfied that it was clear that when he was discovered, the man was already dead and could not be resuscitated. However, this will not be so in every case. The prison immediately raised this question with the investigators when they opened the investigation. The Governor said that they had already ensured that calling an ambulance is included in the contingency plans. The staff in the communications room were now aware that it is their responsibility to undertake this duty. Calling the ambulance had also been included in the duty governor action sheet to ensure that they are aware of the importance of the action. I am pleased that the Governor quickly recognised the confusion about calling an ambulance and took immediate steps to issue clear guidance to her staff. I have decided that a recommendation is not necessary as action has already been taken to rectify the confusion.

The ligature

77. The ligature tied around the man's neck was not immediately removed by the staff who responded to the emergency. I understand that this was because it was clear that the man had died and could not be resuscitated. The Governor also brought this issue up with the investigators on their opening visit. She realised that, in future situations, it may not be clear that the person cannot be resuscitated. I am pleased to record that the Governor has now issued further guidance to staff involved in responding to a suspected death in custody. This guidance makes clear the importance of removing any ligature immediately, and again I do not make a recommendation in this regard.

Liaison with the man's family

Breaking the news to the man's wife

78. The man's wife was upset that the news of her husband's death was broken to her over the telephone whilst she was at work. She was then asked to write down a telephone contact number. PSO 2710 (Follow-up to deaths in custody) makes clear the recommended method of breaking the news:

> "The family should be informed face to face as soon as possible after the death."

79. However, the PSO also acknowledges that this option is not always possible. It does say that using the telephone should only be used as a last resort. The investigators were told there were a number of reasons why the telephone was used. Firstly, the pastor had already called the prison to enquire after the man's well-being as he had not made his regular morning call to his wife. The prison realised she might already be worried. They thought that refusing to confirm her concerns until someone could drive two hours to see her could be seen as obstructive. The prison was also aware of the high profile nature of the man's offence and was concerned that the news would be leaked to the media before she could be told in person. I understand that this belief was well-founded as the news was leaked to the media within an hour of his death.

80. I accept that using the telephone was the only reasonable thing for the prison to do, albeit one that should be avoided wherever possible. However, the manner of the telephone conversation was also troubling for the man's wife. She was not comfortable about being told to note down a telephone number immediately after being told of her husband's death. This illustrates that telephone conversations are particularly prone to misinterpretation. Not leaving a telephone number would have been equally neglectful. The manner of such a conversation is important for the relationship with the bereaved family and must be conducted carefully and respectfully.

The Governor and FLOs should review the sections of PSO 2710 regarding the breaking of the news to the family, particularly if the telephone has to be used.

81. The National Offender Management Service (NOMS) suggested that this recommendation be omitted since the report agrees that telephoning the man's wife was the only option in the circumstances. However, the recommendation was made due to the tone and content of the telephone conversation, and in order for such conversations to be carefully considered if they are to be used in the future.

82. I understand that Reverend A took over the family liaison role from Governor B following the telephone call. The chaplain correctly realised that Governor B might be an inappropriate choice of FLO given his part in the decision about ending the pastoral visits. This was important and prevented any further erosion in the relationship with the man's wife.

83. The PSO also says that:

> "If face-to-face prison notification is not possible, there should be swift face-to-face follow-up."

84. It is reassuring that the prison went to visit the man's wife later that day. A personal visit is particularly necessary when the initial news has been broken over the telephone.

The man's property

85. The man's wife wished to know what had happened to a hat that she had sent to her husband. She said that, as it had not been delivered to the man, she had sent a second hat, which had also gone missing. Officer C remembered that the man had asked about the hat and the officer had been able to establish that it had not been received into the establishment. Officer C told my investigators that the man had told him that he was going to ask his wife to send another. The investigators asked Garth for any further information regarding the hats but have not been able to discover anything further. I am sorry that I am unable to answer the man's wife's question.

86. The man's family returned to the issue in their comments to the draft report, saying that the unavailability of the hat may have been a factor in his death. I

accept that the missing hat was frustrating for the man and his family, and have attempted to discover how strongly the man felt about it. The investigators have spoken to the prison and the man did not complain about the hat, or do any more than mention it to his personal officer. Unfortunately, I am limited to the evidence that available, although I acknowledge the importance attached to the missing hat by the man's family.

87. The man's wife was also unhappy that the prison returned all of the man's belongings to her, without first checking what she actually wanted. She found this upsetting. The investigators spoke to Reverend A, the family liaison officer, who said that a form was given to the man's wife listing all of the items when he returned the property. I do not find anything untoward in the prison's actions but remind them of the sensitivity of handling the deceased's property. PSO 2710 includes a suggestion that the family is asked how they would like to receive the property and this should be considered as families may react differently when receiving the property.

Verbal abuse of the man

88. The man's wife was also concerned that her husband may have been verbally abused by other prisoners while working on the gardens and taunted by officers for wearing several layers of clothing when it was cold. The investigators asked prison staff if they were aware of such behaviour by prisoners and other staff. They consistently said that they had never seen the man being treated in such a way. It is worthy of note that the man's personal officer did not recall the man ever raising such a concern with him. The investigators have also seen no record of such allegations in the man's file. I understand that this may be frustrating for the man's wife but am unable to provide any further information.

Funeral expenses

89. PSO 2710 (Follow-up to a death in custody – FLO guidance) says:

> "Offer to pay <u>reasonable</u> funeral expenses or, if the family want particularly expensive arrangements, offer a contribution. £3,000 is the sort of figure considered reasonable in 2005-06 but do not quibble over small sums."

90. However, Garth did not make this offer to the man's wife, although they did arrange to pay to transport his body to his family. Although in previous deaths the prison had contributed to the cost of the funerals, there appeared to be a degree of confusion by staff about when a contribution should be offered to bereaved families. It is disappointing to learn that an important aspect of the prison's assistance was managed poorly. The investigator, once he became aware that the man's wife had not been offered a contribution to the expenses, spoke to the Governor about his concern. The Governor agreed to make a contribution to the funeral costs.

The Governor should review the requirements of PSO 2710 to ensure that the offer to contribute towards funeral expenses is part of the family liaison process.

CONCLUSION

91. The man was, by all accounts, a private man. He did not share his feelings with many staff or prisoners and there appears to have been no evidence in late 2009 and early 2010 that he was planning to take his life. He did give away items to other prisons but this did not arouse the suspicions of the prisoners receiving the items. I cannot fault the prison for not recognising he was a suicide risk. I believe that the care received by the man was of a good standard, except that the prison did not manage the issue of the pastoral visits well.

92. Following the man's death, the prison engaged with the man's wife although it was disappointing to hear she had a number of issues regarding their liaison with her. Most importantly, a contribution towards funeral expenses was not immediately offered and paid. The prison must ensure that this does not happen again.

RECOMMENDATIONS

1. The Governor should consider PSO 4550 and ensure that decisions are consistent and clearly explained to prisoners and their faith leaders.

   The National Offender Management Service accepted this recommendation and wrote:

   > "Functional Heads and Chaplaincy written to and advised that PSO 4550 must be adhered to and decisions must be consistent."

2. The Governor and FLOs should review the sections of PSO 2710 regarding the breaking of the news to the family, particularly if the telephone has to be used.

   The National Offender Management Service suggested that the recommendation be omitted since the report agrees that telephoning the man's wife was the only option in the circumstances. However, the recommendation was made due to the tone and content of the telephone conversation, and in order for such conversations to be carefully considered if they are to be used in the future.

3. The Governor should review the requirements of PSO 2710 to ensure that the offer to contribute towards funeral expenses is part of the family liaison process.

   The National Offender Management Service accepted this recommendation and wrote:

   > "The Chaplaincy and FLO are now absolutely clear about the requirement to pay funeral costs."