

**Investigation into the circumstances surrounding the
death of a man at HMP Manchester
in January 2008**

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

July 2008

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Manchester on 11 January 2008. Shortly before 5.00pm that day, a man was found hanging in his cell in the Vulnerable Prisoners Unit. He was from another country, spoke little English and was 29 years old.

I offer my sincere condolences to the man's family and friends for their sad and untimely loss.

The investigation was conducted by one of my colleagues. I also commissioned a clinical review of the management of the man's health needs while he was in custody at Manchester.

I would also like to thank the Governor of Manchester and his staff for the help and co-operation they offered during the course of the investigation. I pay particular tribute to the investigation liaison officer who was exceptional.

In February, one of my family liaison officers telephoned the man's uncle to arrange a home visit to discuss the investigation. He said he did not wish to be visited at home but confirmed that he did want to see my report. The man's uncle raised a number of concerns about the nature and cause of his nephew's death. I trust these are addressed in this report.

The investigation found that the care afforded to the man was appropriate. However, I make four recommendations. The clinical review makes an additional eight which I endorse.

Stephen Shaw CBE
Prisons and Probation Ombudsman

July 2008

CONTENTS

Summary

Investigation process

HM Prison Manchester

Key events

Issues

Recommendations

SUMMARY

The man appeared at Magistrates' Court on 12 October 2007, charged with a serious offence against his wife. He vehemently denied this charge, claiming his wife made the accusation because he would not buy her a house. The man was refused bail as he was an illegal immigrant. He was taken to HMP Manchester, arriving at about 5.30pm. This was his first time in prison. The man could speak little English.

During the reception procedures, the man said he had no major concerns about his health and did not have any mental health history. He said that, although he was in prison, he did not feel suicidal. He was advised to apply for segregation because of the nature of his alleged offences. He did so and was initially allocated a single cell in the induction wing and kept apart from other prisoners. Three days later, the man made superficial cuts to his wrist and leg. He claimed he did this because he was frustrated at having to remain in his cell for long hours with little to do. He was taken to the healthcare centre for assessment and a doctor decided to admit him as an inpatient. Formal self-harm monitoring (Assessment, Care in Custody and Teamwork - ACCT) procedures were also invoked. The man remained in the healthcare centre until 26 October when he was considered to be well enough to return to a wing. He was located in K Wing because the Vulnerable Prisoners Unit (VPU) was full. He remained there until 30 October when he transferred to the VPU.

The self-harm monitoring procedures remained in force until 6 November when it was thought the risk of further self-harm had diminished. Thereafter, he seemed to settle into a pattern of hard work and befriended a small group of foreign national prisoners who could speak his language. He shared his cell with another prisoner who helped him fill in forms and to communicate with wing staff. Although he was anxious about a number of matters such as the possibility of being deported, his forthcoming trial, and his wife and daughters whom he dearly loved, the man gave the impression that he was coping reasonably well. He gave no one, not even his uncle whom he telephoned regularly, any indication that he was contemplating suicide.

During the afternoon of 11 January 2008, the man apparently took his own life by hanging while his cell mate was at an education class.

My report concludes that, although there was no evidence that the man underwent a secondary health screen, and there were minor flaws in the ACCT procedures, the medical and other care afforded to him at Manchester was appropriate. Although he spoke little English, there is no evidence that he was unduly disadvantaged by any language difficulties. I do not believe his death could reasonably have been predicted or prevented. The prison promptly informed his family of his death. Staff and prisoners were also offered appropriate support.

I make four recommendations in respect of ACCT, care plans and calling an ambulance in an emergency situation. I endorse the eight further recommendations made by the PCT relating to various clinical matters.

INVESTIGATION PROCESS

The investigation was opened on 13 January 2008 by one of my Assistant Ombudsmen. He met the Governor of Manchester to brief him on the nature and scope of the investigation. On the same day, notices were issued to staff and to prisoners inviting anyone with information or concerns about the man to contact my investigator.

The investigation was carried out by one of my colleagues, who began his work at the prison on 15 February. On that day, he met the Deputy Governor and representatives of the local Independent Monitoring Board (IMB) and the Prison Officers' Association (POA). The meeting was also attended by the Clinical Reviewer who had been commissioned by Manchester Primary Care Trust to undertake a clinical review of the management of the man's health needs. A Senior Officer, who was the investigation liaison officer, also joined the meeting as did a Detective Sergeant from the Greater Manchester Police. The PPO investigator briefed those present on his terms of reference and methodology for the investigation. Thirteen members of staff and three prisoners were interviewed subsequently. Police witness statements were also made available to my investigator.

In February 2008, one of my Family Liaison Officers, telephoned to introduce herself to the uncle, in order to ascertain the extent to which he wished to be involved in the investigation. The uncle confirmed that, while he did not wish to be visited, he wanted to be kept abreast of developments during the course of the investigation and to receive a copy of this report.

HMP MANCHESTER

HMP Manchester, formerly known as Strangeways, is a Victorian local prison within the Prison Service's high security estate, situated not far from the city centre.

At the time of the investigation, the prison served Magistrates' and Crown Courts in the Greater Manchester area, and held up to 1,269 male adult prisoners, including a number of category A (high security) prisoners. Its accommodation comprises two Victorian radial buildings containing nine wings or units with a mix of single and double cells, a segregation unit and a healthcare centre.

Healthcare at Manchester is commissioned by the Manchester Primary Care Trust. The healthcare centre provides 24 hour nursing care and medical cover and has beds for up to 38 prisoners.

HM Chief Inspector of Prisons, last inspected Manchester in May 2007. In the report of that inspection, published the following October, Ms Owers recorded her view that:

“Despite population pressures, purposeful activity and resettlement provision for Manchester's wide range of challenging and needy prisoners remained generally sound and staff-prisoner relationships had improved since our last visit. Nevertheless, we note a number of safety concerns, both for the prison and for the National Offender Management Service, that need to be addressed as a matter of urgency.”

Under the heading “Safety”, the Chief Inspector of Prisons went on to say:

“There had been a large number of deaths in custody over the past three years and it was of concern that there had been some recurrent recommendations arising from investigations by the Prisons and Probation Ombudsman, particularly weaknesses in record keeping. The safer custody manager had insufficient time for her role.”

This investigation into the man's death found evidence of minor flaws in record keeping.

In their report on Manchester for the period 1 March 2006 to 28 February 2007, the prison's Independent Monitoring Board made the following general comment:

“During the year, HMP Manchester has continued to prove its excellence. It has been awarded High Performance status and has achieved the Investors in People award. The Board is proud on the prison's behalf of these achievements during what has been a problematic, overcrowded year.”

The Board drew attention to their concern that about 90 per cent of inpatients in the healthcare centre had mental health problems. They reported that 60 per cent of prisoners on open ACCT forms were inpatients. They said there had been two

deaths in custody in the healthcare centre during the reporting period but several incidences when members of staff had successfully intervened. The Board commented:

“It is thanks to their dedication and action above and beyond the call of duty that more deaths have not occurred. There have been many incidents of self-harm, some very serious. The staff do everything they can to prevent prisoners harming themselves. However, at times it is distressing for staff, as often a wound is barely healed before a prisoner bleeds himself again, and the process of treating him starts over.”

None of the recommendations I have made in previous investigations at Manchester is relevant here.

KEY EVENTS

Court appearance

The man appeared at Magistrates' Court on 12 October 2007, charged with a serious offence against his wife. He was refused bail due to the seriousness of the offence. He was remanded in custody at Manchester prison. The man was from outside the United Kingdom.

Reception at Manchester

The man arrived at Manchester at about 5.30pm. The Prisoner Escort Report (PER) for the journey between the court and the prison carried no notations that he presented any medical, security or other risks, including that of self-harm.

An officer saw the man on reception. Realising he could not speak English very well, the officer used BIG WORD, a system by which a dedicated telephone number is used to call an appropriate interpreter to translate between English and the mother tongue of a foreign national prisoner. Both the prisoner and the member of staff talking to him can hear the interpreter on separate telephone sets. The BIG WORD facility used by discipline staff in reception has to be shared with the healthcare staff.

The man told the officer he was born on 5 July 1979 and was married with three children. He told the officer where he was from and was unemployed. The officer offered the man a free reception telephone call to his family. However, as he had no telephone numbers on him, he could not make any calls. Neither could the officer make any calls on his behalf. The officer told my investigator that all prisoners are also offered a call to their legal adviser but, for the same reason, the man could not use this facility.

Health screen

A nurse conducted a first reception health screen on the man the same day (12 October). The man once again gave his date of birth as 5 July 1979. He said he had been living at an address in Greater Manchester prior to his arrest. He gave no details of any doctor he had attended. No health information had been received at Manchester from any outside source.

The man told the nurse he had been in custody before but gave no details as to when, why or where. (The investigation found no evidence that he had been in prison in the UK before.) He said he had not been homeless during the previous year, and had not seen a doctor in that period. He was not taking any prescribed medication. However, the man told the nurse he had experienced chest pains and that he kept going to the toilet to pass water. He said he never used alcohol or drugs. He added that he had never been referred to a psychiatrist for any reason, and had never received any medication for mental health problems. The man told the nurse he had never self-harmed and did not feel suicidal after being imprisoned. The health screen form shows that the man asked to see a doctor and was referred. However, the investigation found no evidence that he actually saw a doctor during the reception process. He was considered fit for normal cell occupancy and work.

There is a requirement that each new prisoner should undergo a secondary health screen within a short time of arrival. The purpose of this screen is to enable medical staff to assess prisoners' specific health needs once they have settled. There is no evidence that a secondary health screen was carried out for the man.

The author of the clinical review of the management of the man's health needs, notes that whereas the nurse, a Healthcare Assistant (HCA), knew that she was meant to be supervised by a Registered Mental Health Nurse (RMN), the RMN could not recall being asked about the man or to ensure that the man saw a doctor during the reception process.

The clinical reviewer also points out that the form used by the nurse contains boxes for staff to tick or cross when given answers by prisoners during the reception interview. The clinical reviewer comments that questions answered by a single box for ticks and crosses can be open to misinterpretation.

Cell sharing risk assessment

The officer and the RMN carried out a cell sharing risk assessment to assess the man's risk of harming others, before deciding whether he should be placed in a single or a shared cell. This risk had to be balanced with the man's risk of harming himself. The assessment confirmed that the man had no previous convictions for any violent offences. He told the officer he had never abused alcohol or drugs. He also said he had no history of self-harm. The RMN indicated that there were no health issues indicative of any risk of him harming others. She also recorded that there were no concerns about any risk of the man harming himself. The man was therefore assessed as suitable to share a cell.

Application for separation

As soon as the officer saw the nature of the man's alleged offence, he advised him that it might be in his best interests to apply to be located in the Vulnerable Prisoners Unit for his own safety. This was authorised immediately by a senior manager.

Opening of ACCT (Assessment, Care in Custody and Teamwork) for minor self-harm and admission to healthcare centre

On 15 October 2007, the man made a number of scratches to his wrist and leg using a shaving razor issued or bought in the prison shop. An officer, who saw him in his cell after he had done this, completed a form F213SH - a report of an injury to a prisoner caused by self-harm. At interview, the officer confirmed that the man was in a double cell in K Wing at the time. He thought that his cellmate might have pressed the cell bell to draw the attention of staff to what the man had done. As far as the officer could recall, he found the man lying unresponsive on his bed or on the floor of his cell. The officer said he could see cuts to the man's wrist and leg. He was bleeding superficially from both injuries. The officer confirmed that prisoners were permitted to keep razors in their possession unless on an Assessment, Care in Custody and Teamwork (ACCT) form. (This is a document used to monitor those

prisoners considered to be at risk of self-harm or suicide.) The officer thought the man was feigning unconsciousness.

The officer summoned the unit manager, who was a Senior Officer, to the man's cell. At interview, the unit manager also recalled seeing the man lying on the floor, and that other staff were in the cell with him. He too described the man as unresponsive and thought he was feigning unconsciousness. The unit manager said:

"I told my colleagues we have to take the man to the healthcare centre. As soon as I said that, he got up. He must have understood what I said. When he stood up he looked ok. He wasn't bleeding very much. He must have cut himself using a razor issued for shaving or a plastic knife. I don't think there was much intent. I don't remember there being another prisoner in the cell with him. I think I was the one who phoned the healthcare centre to ask for help."

The officer said he thought he knew the nurse who came to the cell and took the man to the healthcare centre.

The nurse made the following entry in the man's clinical record:

"Hotel 1 call out. Feigning unconsciousness. Refused to accept treatment. Had a couple of scratches to wrists and left calf. Advised to leave under supervision and I would attend later. Since then he has wrecked his cell and has been brought across for assessment."

The unit manager said he had no knowledge of the claim that the man damaged his cell before he was taken to the healthcare centre.

The unit manager decided to open an ACCT monitoring form. Whenever an ACCT form is opened, the Prison Service requires the following measures to be taken:

A concern and keep safe form should be opened immediately.

This form is used to help staff identify the main problems that caused the prisoner to become at-risk. The unit manager opened a concern and keep safe form at 2.00pm on 15 October. He completed only one of the boxes available on the form because, he said, the man was taken straightaway to the healthcare centre for assessment. In that box, the manager wrote:

"Discovered in K2-40 having cut his wrist and leg. Feigned unconsciousness. When round, taken to HCC (healthcare centre)."

An immediate action plan must be drawn up.

The aim of the immediate action plan is to consider and record the most appropriate environment and regime to support the person at-risk prior to the first ACCT case review. An immediate action plan was drawn up for the man by a Senior Officer and a Staff. A doctor saw the man and agreed to admit him to the healthcare centre as

an inpatient. It was further agreed that the man should be placed on an intermittent watch. This required staff to make four 'conversational' entries during the day and four further entries during the night. The man's ACCT record shows these entries were duly made.

An assessment interview must be conducted with the at-risk prisoner within 24 hours of the initial concern being raised.

This assessment helps staff to gain information that will be useful in formulating ideas as to the severity of the risk of self-harm and how best to monitor and manage the person concerned.

An officer carried out the assessment interview with the man. The officer wrote that the man had entered the country illegally and had married in order to be permitted to remain in the United Kingdom. He told the officer his wife was behaving badly because he did not want to buy her a house.

The officer recorded that the man wanted to kill himself when he self-harmed. The man told the officer he did not consider himself to be mentally ill but was low in mood and tearful because he did not like being in prison. The man said he felt better when he self-harmed "because of current problems". The officer described the man as very low and confused as to whether he wanted to die. The man felt he had nothing to live for other than to prove his innocence.

At 7.00pm that day, the officer and the man agreed the following actions:

- To place him in a cell with a prisoner who could speak his language.
- To assist him to involve himself with wing activities.
- To assist him to engage a solicitor.
- To assist him to contact his friend via a solicitor.
- To give him a telephone call.

The man was placed in a safer cell. This is a single cell designed and equipped in such a way as to reduce the number of ligature points.

A first case review must also be conducted within 24 hours of the initial concern being raised.

The man's first case review was convened immediately after the officer had drawn up the immediate action plan. The panel comprised of a Senior Officer who was in the chair, together with the officer and the man himself. The review took place in the healthcare centre. The review was summarised as follows:

"Case review based on Big Word. Discussed involving the officer. The following points need actioning tomorrow:
Try to locate with Bengali speaking prisoner.
Get friend's phone number from solicitor."

The panel judged the man's risk as being raised and set a further review date of 22 October. He was to be observed intermittently. This meant that staff was required to observe him at least five times per hour and at irregular intervals.

A care and management plan (care map) should be drawn up.

The purpose of the care map is to identify actions that will disable any suicide plan; link the at-risk prisoner to people who can provide support, build on any strengths or interests the prisoner may have, and encourage alternatives to self-injury. The care map in the ACCT form presented to my investigator was blank.

Further assessment by a doctor

The next day, a doctor saw the man and confirmed his admission as an inpatient in healthcare. He wrote in his clinical record,

“Looks much better today. Still very difficult contact due to his very poor English. No evidence of agitation. Normal behaviour. No evidence of self-harm/suicidal risk at present. Stop intermittent watch. Continue anti-ligature cell. Review tomorrow.”

On 17 October, the following entry was made in the man's prison record by an officer:

“.. Still very upset that his wife has accused him of this crime. They were living together happily until two months ago. They have 4 month old baby. Also worried that not been able to phone anyone yet. Asked staff who told me that forms are in progress.”

My investigator was told that, in order to be able to make telephone calls, a prisoner has to open a PIN phone account. This account can only be opened after the telephone numbers the prisoner wishes to use in prison have been checked for their authenticity. The owners of each telephone number also have to be asked if they are content for the prisoner to call them. Initially, the man had no numbers to be registered. The process of opening a PIN phone account for him therefore took longer than normal. My investigator was given a copy of the list of telephone calls he made from Manchester. The list shows he started to make use of the telephone on 21 October.

Second ACCT review

The second ACCT case review took place at 9.30am on 23 October instead of 22 October as originally planned. On this occasion, the panel comprised of two officers and a nurse. Also present was a staff nurse and a 2nd nurse as well as the man. The review took place in the healthcare centre. It was summarised as follows:

“the man appeared quite calm at this review – smiling when spoken to – states he is okay and doesn't wish to hurt himself.”

A fresh assessment of the man's risk of further self-harm concluded that the risk had reduced to 'low'. A further case review was scheduled for 6 November.

On 23 October, a doctor made the following entry in the man's clinical record:

"Normal behaviour in hospital wing. No evidence of mental illness or self-harm tendencies. Sleeps well, appetite good. Emotionally stable. Review on ward rounds of the consultant psychiatrist."

Assessment by mental health in-reach group worker

On 24 October, a mental health group worker wrote in the man's clinical record:

"Attended social/discussion group session HCC (Healthcare Centre). Appeared nervous and anxious. In spite of his limitations to communicate, he was able to ask questions and was attentive to what was happening in session. Other members were keen to encourage and support him."

The next day, the mental health group worker added

"The man attended day care centre group session. Presented anxious but pleasant in mood. Was able to interact and communicate information about himself, with support from his peers in the group, in spite of the language barrier."

The investigation found that the healthcare centre did not have appropriate nursing assessment documentation, and that the nursing care plan provided was gained from the doctor's interview with the man. The paper care plan was not signed or dated because it had been printed from the electronic copy.

ACCT case review prior to discharge from the healthcare centre

At 6.40pm on 26 October, a further ACCT case review was convened. The purpose of this particular review was to assess the man's risk before discharging him from the healthcare centre. The panel comprised of a healthcare senior officer, an officer and a nurse. The man was also present. So too was another prisoner who was used as an interpreter. The review was summarised as follows:

"Explained to the man that he will be moving to K Wing. Explained the support system open to him and process he will be going through. He said he understood what was said."

A follow up appointment was made for him to see a doctor a fortnight later. The investigation found no evidence that this took place. A further ACCT case review was to be held on 29 October. However, there is no evidence to show whether that case review took place either.

After having been discharged from the healthcare centre, the man was moved to K Wing where he was allocated a shared cell. K Wing is essentially a remand wing, but it also operates as an overspill unit for vulnerable prisoners when the Vulnerable Prisoner Unit (VPU) is full. The man remained in K Wing until 30 October when a vacancy in the VPU arose. Whilst in K Wing, he occupied a shared cell with another prisoner who was to become his interpreter and friend in the unit.

Final ACCT case review

The man's final ACCT case review was held at 3.45pm on 6 November. The panel on this occasion comprised a senior officer, an officer, and a member of the from Independent Monitoring Board. (I should say in passing that, while well-intentioned, I do not believe that IMB members should be part of an ACCT review panel. This is not a monitoring but a decision-making function, and hence inappropriate for an IMB. I would be grateful if the Governor could share those comments with the chair of the prison's IMB who may in turn wish to consult with the IMB Secretariat or National Council.)

The man also attended the review, as did his cellmate. The review was summarised as follows:

“The man was bright to the review and was open. He has settled onto E Wing (the VPU) very well. He has the support of a number of prisoners and his family. The issues which caused this document to be opened have now been resolved. It was agreed by all present that the document be closed. He was reminded of all the support networks available.”

The ACCT form was therefore closed.

My investigator scrutinised the entries made in the ACCT ongoing record for the period 15 October to 6 November. These showed a clear and sustained improvement in the man's mental state.

ACCT post closure review

An ACCT post closure review was held at 6.30pm on 13 November by a Senior Officer. The date mistakenly shown for the post closure case review was 6 November. The review was summarised as follows:

“The man has settled down on the wing. He has a number of friends on the wing and he attends work. No more concerns at this time and the form can remain closed.”

There is no evidence to show that any other member of staff or prisoner attended this review.

Appearance at court

On 31 December 2007, the man was taken to Crown Court. He was remanded in custody at HMP Manchester once again, this time to await confirmation of a date for his trial to begin. The Prisoner Escort Record (a form that accompanies each prisoner on escort to provide a chronological record and to communicate risks a prisoner might pose on escort or transfer) for the journey to the court carried the notation that he was vulnerable because he had been located on the VPU. However, it included no indication that the man was at risk of self-harm or suicide. The man returned to the prison later that day. He was seen by a nurse who noted in his medical record that there were no problems.

Events on 11 January 2008

The man was due to go to work on 11 January but complained of a stomach ache. An officer allowed him to remain in his cell.

The man's cellmate, said in a statement he gave to the Greater Manchester Police that prisoners were locked in their cells during the morning of Friday 11 January because of a staff funeral. He said he and the man were in the cell together from 7.45am until midday. Throughout that time the television was on. The cellmate said he watched BBC News 24 from his bunk while the man remained on his prayer mat, praying the whole time. The cell mate said the man was chanting and reciting from the Qur'an. He thought the man's behaviour that morning was no different to anything he saw during the previous three weeks. The cellmate went on to say:

"About a week and a half prior, the man had started with a cold and yesterday morning he was coughing. I was aware that the man wasn't feeling very well. I had told him to take some of my paracetamol but he wouldn't.

"At 12 midday, an officer unlocked our door where we were allowed access to our lunch on the servery. Both the man and I were fasting, through our own choice. I had started at New Year but the man started on Thursday (10 January) for the Islamic New Year. The man and I went to collect our food which was already prepared on trays and went back to our cells where we left them until we could eat at the close of our fasting. He placed his food in his cupboard. I have no idea what it was. My food was a snack pack and I placed it on the table. Shortly after the man left our cell and went over to another prisoner's cell (29) where he stayed for a couple of minutes and returned with a book.

"The book was an Arabic prayer book. We were then locked in for a further two hours. During that time, the man prayed and read his prayer book. I prayed myself and then watched the TV prior to 2.00pm. The man told me he wasn't feeling well and wasn't up to going to work that afternoon. I asked him if he wanted me to have a word with an officer on his behalf. The man said yes. When the door opened, it was another officer. I told him the man wasn't well

and if he would be excused. The officer said he would still have to report to an officer downstairs.

“We both left the cell and I saw the man approach the officer downstairs. I didn’t hear the conversation but he approached me shortly after. He put his thumbs up in an ok motion, waved and smiled. The man then climbed the stairs back towards our cell. I didn’t see him again.

“At 4.20pm, I returned to my cell with an officer. He opened the door but prior to doing so I opened the hatch and saw paper was covering the glass. As the door opened, I went to put the light on as it was in darkness when I saw via the outside lighting that the man was hanging by the bars at the window. I was immediately pushed to the side out of the way by the officer and only saw the man for a few seconds. He was still and I knew he had died. I couldn’t see what he was hung with or how he was hung. I was shocked and just froze.

“I had no idea he had any intentions to taking his own life. He never spoke to me about committing suicide and never communicated any intentions of his actions at all. I feel very sorry and upset that the man has taken his life.”

The officer told my investigator he was on duty in the VPU all day on 11 January. He confirmed that all prisoners were kept locked up that morning because of a staff funeral which he did not attend. The officer said he did not have any contact with the man until about 11.45am when lunch was served. The officer remembered seeing him come out of his cell to collect his meal. The man passed the point where the officer was standing. The officer said he may have nodded to the man but he did not have any conversation with him. He appeared to the officer to be “no different to any other time”. The man gave him no impression that he was about to take his own life. A few minutes later, he returned to his cell with his meal. The officer could not remember whether the man’s cellmate was with him.

At about 2.00pm, another officer unlocked the man’s cell to enable him to go to work and so that his cellmate could go to his education class. The man told him he was not feeling well and wanted to stay in his cell. The officer advised the man to report to the officer on the ground floor of the wing. The same officer was the officer who had the authority to decide whether he could remain off work.

The officer was the movement’s officer at the time. The man and his cellmate approached him together. The man told the officer he was not feeling well, having been suffering from a heavy cold during the previous few days. As the officer knew the man had a poor command of English, he asked his cellmate if there was a problem. The cellmate told the officer that as far as he was aware, the man was fine other than feeling the effects of the cold. The officer took the view that, as the man was normally a good worker who regularly attended for overtime at weekends; he could have the afternoon off. The officer told him this and advised him to seek the advice of a nurse if he did not feel any better at tea time. The man returned to his

cell and his cellmate went to his education class. He remained in his cell on his own during the afternoon. At no stage did he press his cell call alarm.

Shortly after 4.00pm, work and education classes ceased for the prisoners in the VPU. The prisoners therefore began to return to their landings. At about 4.20pm, an officer began to unlock the prisoners in their cells. As he unlocked cell E4-V17 to allow the cellmate to be locked up, the officer noticed "something against the bars at the back of the cell". As it was dark, he switched the cell light on and saw the man hanging from the window bars. He shouted for assistance and took the man's weight. As he was doing so, two more officers entered the cell. One of the officers helped the officer who unlocked the cell elevate the man's body while the other officer cut the ligature away from the window with her anti-ligature knife. Two officers then lowered the man to the floor. One of the officers told my investigator he noticed the man had fixed a table leg horizontally to his window bars which he had used as a suspension point for the ligature made from a bedsheet. The officer did not notice any other material used by the man in the construction of the ligature.

A senior officer, who had heard the call for assistance, pressed the alarm bell and ran to the cell. As soon as she saw what had happened, she told a number of other staff who had arrived to call for urgent medical assistance.

Once the man had been laid on the floor, one of the officers cut the ligature away from his neck. Two officers then began to administer cardio pulmonary resuscitation (CPR). Despite the fact that there was no response from him, they continued to apply CPR until relieved by another officer and two nurses. One of the nurses said that, as soon as she heard the call for assistance over the radio, she left reception with principal officer (PO) and collected the emergency bag and the defibrillator from the central rotunda en route to the VPU. On arrival at the cell, a nurse attached the electrodes for the defibrillator to the man's chest and asked her colleagues to stand clear whilst it analysed the man's cardiac rhythm. The defibrillator gave the instruction "no shock advised – check for pulse". No pulse could be found. CPR was therefore continued. A nurse checked the man's pupils and found they were fixed and dilated.

In a statement read by my investigator, a governor said she was in her office on the second landing in the prison's rotunda when she heard the alarm. The governor said she went to the cell and saw a number of staff attempting to resuscitate the man. She explained in her statement who was undertaking which function. The governor said that she borrowed a radio from a colleague and asked for urgent medical assistance to be sent to the cell. The nurse and a PO arrived as a result of her call. The governor said she asked the nurse if an ambulance was needed which the nurse confirmed. The log of events shows that the prison's control room was asked to call an ambulance at 4.29pm; some eight minutes after the initial alarm had been raised. The request was passed from the control room to the Ambulance Service two minutes later. An ambulance arrived at the prison gate at 4.46pm and the paramedic crew arrived at the cell at about 4.47pm. CPR was continued until the arrival of a doctor at about the same time as the paramedics. The doctor said that, by the time he arrived, "full protocol CPR including application of fully automated defibrillator, ambu-bag with high flow oxygen O2 had been ongoing for more than 30 minutes by fully qualified staff, including nurses". The doctor asked the paramedics

to “run a rhythm strip over half a minute approximately which showed definite asystole”. (A rhythm strip is a means by which the heart beat can be measured and shown on a graph. Asystole indicates no cardiac output.) The doctor examined the man and found there were no carotid or femoral pulses, no heart or respiratory sounds and no movements present. The doctor therefore confirmed the man’s death at 5.00pm.

The investigation found that some staff either used no protective face masks or inappropriate masks when applying CPR.

When the police examined the man’s cell they found a long piece of material they thought he might have used to tether himself to prevent any chance of rescuing himself once suspended. Only one of the members of staff interviewed by my investigator - a nurse - remembered seeing this piece of material. The nurse said she noticed that one end was tied to one of the man’s feet. However, she said she did not think it was tied to anything at the other end.

Informing the next of kin

The Muslim chaplain telephoned the man’s brother in another country at about 6.45pm to break the news of his death. The brother asked the chaplain to pass on the news to the man’s uncle in Oldham. The brother expressed his desire for the man’s body to be returned to his own country for burial. At about 7.15pm, the chaplain informed the man’s uncle and offered him his support. Arrangements were made for the uncle to go to HMP Manchester to see the man’s cell and to talk to staff about the circumstances of the man’s death.

The Governor paid for the man’s body to be repatriated to the man’s own country.

The man’s uncle said he was very grateful for the help given by the prison and felt staff could not have done more. He also mentioned that the man’s family in his country had been touched to receive a letter from the Governor. He was particularly appreciative of the support given by the Imam.

Staff and prisoner care

Immediately after the man had been pronounced dead, the chaplain comforted two of the man's friends as they were very distressed. He arranged for one of them to see a doctor.

The Governor issued a notice to prisoners and staff informing them of the man's death. Those prisoners who were subject to ACCT procedures were reviewed in order to assess their reaction to the news. All those staff interviewed by my investigator were full of praise for the level of care and support offered to them by their managers and by the prison's care team.

ISSUES

Here I examine:

- Whether the man's health needs were properly assessed and met.
- Whether his risk of self-harm or suicide was properly assessed and managed.
- Whether he was given appropriate support and facilities, given his status as a foreign national prisoner.
- Whether his death could have been predicted and, therefore, prevented.
- Whether the emergency first aid was prompt and effective.
- Whether appropriate courtesies were afforded to the man's family in the aftermath of his death.

I also address the concerns expressed by the man's family.

Were the man's health needs properly assessed and met?

As the man was from another country and spoke little English, not much was known about his physical and mental health history when he arrived at HMP Manchester on 12 October 2007. There was no evidence that he had been in prison in this country before.

The man underwent a full health screen as part of the reception procedures. The assessment was undertaken using BIG WORD, a system using an interpreter over the telephone. The author of the clinical review suggests that it would be better for healthcare staff to have an office of their own in reception rather than having to share the BIG WORD facility with discipline staff.

The man was able to confirm he had no major concerns about his physical health, although he did disclose that he wanted to see a doctor about the frequency with which he had recently been passing water. As far as his mental health was concerned, the man said he had no psychiatric history and did not feel suicidal now that he was in prison. The nurse who conducted the health screen referred the man to a doctor. There is no evidence that an appointment took place. The man's presentation was such that, in the opinion of the healthcare assistant who conducted the health screen, there were no grounds for believing he was at risk of self-harm or suicide.

The clinical review found no evidence that the healthcare assistant who conducted the health screen was properly supervised by a Registered General Nurse. The clinical reviewer recommends that the Director of Healthcare at Manchester should reinforce the need for trained staff to validate the actions of healthcare support workers. The clinical reviewer also recommends that the Director should ensure there is no breakdown in communications between the various staff involved in the reception process.

The clinical reviewer points out that the form used for the reception screen contains boxes for staff to tick or cross in relation to answers given by prisoners during the interview. She suggests that answers recorded in this manner can be open to misinterpretation and recommends that a more robust recording method should be

adopted. Having found evidence of poor record keeping in the man's nursing care plan, the Clinical Reviewer also recommends that changes to documentation should be clearly signed and dated.

The investigation found no evidence to show that a secondary health screen was conducted. The purpose of this screen is to assess a prisoner's detailed needs once he has settled into the prison. It should normally take place within two days of the prisoner's reception. I consider that this omission was not to the man's detriment as he was admitted to the healthcare centre only three days later where his health needs were appropriately identified and met. Whilst I therefore make no formal recommendations on this matter, healthcare staff should guard against similar omissions in the future.

During the reception procedures, the man was advised that it would be in his best interests to apply for segregation because of the nature of the offences for which he had been charged. His segregation was immediately authorised and he was placed, as a temporary measure, in a single cell in the induction wing and kept apart from other prisoners. Three days later, the man inflicted minor cuts to his wrist and leg. He was therefore admitted to the healthcare centre by a doctor, an associate psychiatrist at Manchester. The man remained an inpatient until 26 October 2007 when it was decided he was well enough to return to a wing.

The clinical reviewer found evidence of a lack of nursing assessment for prisoners admitted to the healthcare centre, and recommends that these should be developed and implemented as soon as possible.

During his period in the healthcare centre, the man was monitored by the doctor and one of his colleagues, also a psychiatrist. The man was also counselled by a mental health group worker. The man was also subject to ACCT procedures. This served to enhance the level of care he was given. However, the fact that a formal nursing care plan was not drawn up for the man suggests a lack of diligence on the part of the responsible staff. However, I am satisfied that this omission did not translate into any lack of practical care or concern for him. It is nevertheless important for the establishment to demonstrate the highest procedural and administrative standards, not least to help guard against the risk that similar omissions might in future signal lack of care.

I recommend that the Governor should, in conjunction with the Manchester Primary Care Trust, ensure that nursing and medical staff are reminded of the importance of drawing up a nursing care plan for every prisoner admitted to the healthcare centre.

Notwithstanding these criticisms, I believe the general standard of healthcare given to the man was appropriate.

**Was the man's risk of self-harm or suicide properly assessed and managed?
Could his death have been predicted and, therefore, prevented?**

The man said he had no previous mental health problems when he entered prison for the first time in October 2007. He told reception staff he did not feel suicidal.

There were no grounds for invoking self-harm monitoring procedures at that point. However, as I have said above, ACCT procedures were put in place after the man self-harmed three days later.

ACCT case reviews were convened on 23 October, 26 October and 6 November, when, given the man's improved state of mind, the ACCT document was in my view appropriately closed.

However, the investigation found that no ACCT care map was compiled for the man.

I recommend that the Governor should remind his staff of the need to ensure that a care map should be established for each and every prisoner made subject to ACCT procedures and that the care map should be reviewed and updated as long as the ACCT document remains in force.

My investigator noted that there was no evidence that a case review scheduled to take place on 29 October was actually held. A post closure ACCT review took place on 13 November. The member of staff who conducted that review in the man's presence felt confident that the form could remain closed. I am satisfied, given the man's presentation at the review, that the decision was justified. However, my investigator noticed that the review was conducted by one member of staff on his own. This is not good practice and Prison Service policy requires all ACCT reviews to be attended by a multi-disciplinary team.

The Governor should remind his staff of the requirement for ACCT case reviews, including post closure reviews, to comprise a multi-disciplinary team so that a wide range of opinions can be brought to bear in the decision making process.

That said, I should like to stress that the standard of care given to the man through the ACCT process was in my view appropriate.

Between the time the ACCT form was closed on 6 November and the man's death two months later, he gave no outward signs of suicidal ideation. He seemed to settle into a pattern of hard work in the workshop dedicated to vulnerable prisoners, although some entries made in his prison record show that on one or two occasions in December he failed to attend work without permission. It was about this time that a number of prisoners were struck down by a virus that prevented many leaving their cells. Although there is no mention in the man's clinical record that he was included in this number, there is every possibility that his absence from his place of work in December was caused by the effects of the virus.

The man regularly telephoned his uncle. The uncle later told my family liaison officer that at no stage did the man talk about committing suicide or give him the impression that he would harm himself. The man called his uncle the day before he died. Likewise on that occasion, he gave him no cause for concern.

The man's cell mate told my investigator that the man prayed very frequently before 11 October and always cried after his prayers had ended. However, the cell mate did not interpret the man's behaviour as indicative of any risk of suicide. During the

morning of 11 October, the man appeared to his cell mate to be normal. When the man, with the cell mate's help, asked an officer for permission to remain off work because he said he was unwell, neither the man's cell mate nor the officer thought that the man was behaving abnormally.

With the benefit of hindsight it seems likely that the man planned to stay off work so that he could take his life undetected. From the evidence offered by the cell mate and the staff who had contact with him in the last days of his life, I suspect the man's decision to take his life was carefully planned. He managed to put on a brave face to his peers, staff and to his uncle while he was preparing to die. I believe his death could not reasonably have been predicted or prevented.

Was the man given appropriate support and facilities given his status as a foreign national prisoner?

The man was from another country but had spent some time in the United Kingdom before his imprisonment in October 2007. His mother tongue was Bengali but he could also speak Urdu. Those staff who had most contact with him thought he could read English better than he could speak it. The investigation found that efforts were made from the outset to help him cope with the language barrier. During the reception procedures, BIG WORD was used. During the ACCT case reviews, it was normal for another prisoner to attend who could speak English and Urdu or Bengali. Translators were also used during the man's time in the healthcare centre.

As soon as the man was transferred into the Vulnerable Prisoners Unit on 30 October 2007, he was placed in a cell with a cell mate who not only regularly translated for him but also became a close friend. Entries made in the man's record show he made good use of the support that stemmed from his friendship with his cell mate and at least two other foreign national prisoners in the wing.

The investigation found no evidence that the man was unduly isolated because of the language barrier. However, it is possible that, as an illegal immigrant, the man expected to be deported to his own country and this prospect frightened him. There was, of course, little staff could do to reduce this anxiety other than to advise him to seek legal advice. His record shows that support was given to him to contact his solicitor. In addition, his uncle had also tried to help by engaging a solicitor and encouraging the man to speak to her about his concerns.

Was the emergency first aid prompt and effective?

As soon as the officer saw the man hanging, he entered the cell and did everything he could to save his life. He was accompanied by other discipline officers who were followed quickly by healthcare staff. Between them, I believe staff made every effort to resuscitate the man.

Appropriate emergency first aid equipment was taken to the cell without delay. All the staff who tried to revive the man felt they were properly trained in first aid. However, the investigation found that some staff had used either no protective face masks or inappropriate masks when applying CPR. The clinical reviewer

recommends that appropriate face masks should be made available and that staff should be trained in their use. I agree.

An ambulance was called at about 4.29pm, approximately eight minutes after the man was found. A paramedic crew arrived at the cell about 18 minutes later. Although the investigation found no evidence that the man's chances of survival were impaired by an apparent delay of eight minutes before an ambulance was called, the hold-up seems too long. A similar delay in future could result in an avoidable loss of life.

The local contingency plans for managing a life threatening emergency set out the following requirement for the control room staff in relation to calling an ambulance:

“On receiving an urgent message regarding an injured or ill prisoner contact Hotel 1 [the code for emergency healthcare assistance] immediately and direct to the scene. On being informed of a prisoner causing self-harm or other medical emergency requiring emergency treatment at outside hospital request an ambulance to attend prison and give as much detail as possible.”

The contingency plans also require the person who discovers a medical emergency to request an ambulance but the instructions give no further detail.

The Governor should ensure that the contingency plans for managing a life threatening situation make clear that an ambulance is called as soon as the emergency is discovered. The Governor should bring this requirement to the attention of all his staff.

Were appropriate courtesies afforded to the man's family in the aftermath of his death?

The man's family were informed of his death promptly. At their request, the Governor arranged for the man's body to be repatriated to his own country and met the costs in full. The man's uncle was grateful for the help given him by prison staff and said his relatives in his own country were touched by to receive a letter of condolence from the Governor. I am satisfied that the Governor and his staff gave kind and proper support to the man's family. (I may also add that the way the prison managed both staff and prisoner care in the aftermath of the man's death was very impressive.)

Concerns expressed by the man's uncle

How was it possible for the man to have made a rope out of bedsheets in the two hours he had available?

Materials such as bedsheets and shoe laces from which prisoners can fashion a ligature are freely available in their cells. Such items are not normally withdrawn from prisoners unless their risk of harming themselves is judged as being very high and imminent. Although we are aware that the ligature was made from torn

bedsheets, it is not clear how the man did this or how long it took. The man was not judged as being at risk of suicide at the time he took his life.

By what means did the man suspend himself from the window?

As noted, the ligature the man used was made from a bed sheet. This was attached to a wooden table leg he had used as a cross bar he tied to the vertical window bars covering his cell window. The cross bar was tied to the metal grill outside the window so that it could not slip downwards under the man's weight. The man then used the cross bar as the ligature point. When the police examined the man's cell, they found another piece of material that the man seemed to have used to tie his feet in such a position as to prevent him from rescuing himself. The only member of staff interviewed during my investigation who could remember seeing that piece of material was a nurse. She noticed that the material was tied to the man's right foot but she could not see where it was fixed at the other end.

Would it have been possible for the man to save himself?

It is not possible to determine whether the man could have saved himself. However, given that it can take as little as 30 seconds for someone who is hanging to lose consciousness, it is highly unlikely.

Was the man sharing a cell with a life sentenced prisoner who had murdered his family?

It would be inappropriate to disclose details of the offences committed by the man's cell mate or of the sentence he was serving.

Why were there no marks on the man's neck?

It is possible that the thickness of the material the man used as a ligature was such as to leave no marks. However, this is not a question I can answer with any authority. It is a point the man's uncle may wish to put to the Coroner.

RECOMMENDATIONS

ACCT procedures

1. The Governor should remind his staff of the need to ensure that a care map should be established for each and every prisoner made subject to ACCT procedures and that the care map should be reviewed and updated as long as the ACCT document remains in force.

2. The Governor should remind his staff of the requirement for ACCT case reviews, including post closure reviews, to comprise a multi-disciplinary team so that a wide range of opinions can be brought to bear in the decision making process.

Nursing care plans

3. The Governor should, in conjunction with the Manchester Primary Care Trust, ensure that nursing and medical staff are reminded of the importance of drawing up a nursing care plan for every prisoner admitted to the healthcare centre as an inpatient.

Calling an ambulance

4. The Governor should ensure that the contingency plans for managing a life threatening situation make clear that an ambulance is called as soon as the emergency is discovered. The Governor should bring this requirement to the attention of all his staff.

The following further recommendations have been made by the PCT:

5. The first screening process was carried out by a healthcare assistant but there is no evidence this was overseen by a registered nurse nor that the man was seen by a doctor. This was a period of transition from a paper system to an electronic one which may have caused some confusion, but systems must be in place to document clearly what happened during the process.

6. The paper first screening document has answers to questions that required a tick or a cross. This method can lead to confusion if the form is not completed clearly. Questions answered by a single box for ticks and crosses can be open to misinterpretation and should be replaced by a more robust method.

7. All changes to documentation should be clearly made, signed and dated.

8. The Director of Healthcare must reinforce the need for trained staff to validate the actions of the healthcare support workers. She must ensure there is no breakdown in essential communications between all staff involved in the reception process.

9. It would be better for the healthcare staff to have an office of their own rather than having to share with discipline staff for the use of BIG WORD, particularly when it is considered how busy this area can be for both discipline and healthcare staff.

10. Nursing assessments should be developed and put in place as soon as possible. Without these assessments robust person centred care plans cannot be developed.

11. On the man's discharge from inpatient care, a follow-up review should be arranged. The nurse in charge of the discharge process must be responsible for checking all appropriate appointments are made and the prisoner is aware of discharge details.

12. The discipline staff are usually the first people on the scene of a health emergency whether this be an acute health episode or a self-inflicted incident and most feel they should start CPR. It was noted during the interviews that some discipline staff are either using no protective equipment or inappropriate protective equipment. They should be provided with recommended face masks and given appropriate training in their use.

At consultation stage, the Prison Service accepted all recommendations.