

**Investigation into the death of a man whilst in the
custody of HMP Leicester in February 2009**

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

January 2010

This is the report into the circumstances surrounding the death by hanging of the man, a prisoner at HMP Leicester, in February 2009. He was only 24 years old.

I offer my sincere sympathy and condolences to his family and friends for their loss. I must also apologise for the length of time it has taken to issue this report and any additional distress the delay may have caused.

The investigation was carried out on my behalf by one of my senior investigators. A clinical review of the man's healthcare at Leicester was conducted by a clinical reviewer on behalf of Leicester Primary Care Trust. I am grateful for his helpful advice. I would also like to thank the Governor of Leicester and her staff for their co-operation and assistance with this investigation.

The man was a young man facing the possibility of a substantial prison sentence. He told staff that his relationship with his partner had ended, although they were still in contact. He had been taken hostage at HMP Nottingham but then appeared to take a more active role in the incident. He was transferred to Leicester, where six days later he was found hanging in his cell.

I can offer no explanation for the man's apparent decision to take his own life beyond the bare facts in the paragraph above. At no time in custody had he suggested either to staff or to fellow prisoners that he might have been at risk.

In the draft report I made four recommendations, covering summoning assistance in an emergency, health screening in reception and the provision of emergency medical equipment and carrying it to the scene of an incident.

After receiving the report, the man's family provided my investigator with a copy of a complaint made by him whilst at Nottingham. This led to further investigation, a new section in the Issues part of the report and a recommendation for the Governor of Nottingham about the investigation of racist incidents.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman

January 2010

CONTENTS

Summary

The investigation process

HMP Leicester

Key findings

Issues

Recommendations

SUMMARY

The man was remanded into custody on 1 October 2008 and taken to HMP Nottingham. He completed an alcohol detoxification programme but refused an opiate detox, saying he would rather detoxify without medical assistance. It was not his first time in prison and he told staff he had no history or thoughts of self-harm.

During his three months in Nottingham, the man referred himself to the drugs services team and completed the Short Duration Programme for substance misuse. Staff warned him several times about not following instructions and took disciplinary action against him. In January 2009, he served 14 days cellular confinement.

On 27 January, another prisoner took the man hostage and barricaded the two of them in his cell. As negotiators spoke to the prisoner, they could hear him discussing the situation and making plans with the man who died. Staff entered the cell and took both men to the segregation unit. A few hours later, the man was transferred to HMP Leicester.

The following day, staff at Nottingham faxed Leicester the adjudication (disciplinary hearing) paperwork for the man in relation to the hostage incident. He denied being involved, and the governor hearing the case referred it to an independent adjudicator (a district judge) because the charge was serious.

On 2 February, the man had an interview with a drugs worker at the prison. The man told her that his relationship with his partner had ended whilst at Nottingham, although he was still in contact with her. He said that he had used drugs at Nottingham because of the stress caused by the break up. He asked the drugs worker if she could help him with a number of issues, including a transfer to HMP Lincoln to be with his brother.

On returning to the wing, he spoke to three prisoners, telling all of them about his relationship problems. He asked two of the men for drugs but they said they could not help him. He telephoned his partner at 3.20pm and they spoke for five minutes about the ending of their relationship and the charges he faced.

At approximately 4.15pm, when his cellmate returned from education, he discovered the man hanging from the window bars. He called to an officer who entered the cell and shouted for assistance. A prisoner and other officers arrived and loosened the ligature. They laid the man on the floor and began artificial respiration. Healthcare staff came to the cell and took over until paramedics arrived. Sadly, they could not resuscitate him and the prison doctor certified his death at 4.43pm.

A governor, chaplain and the Imam went to the family home and broke the news to his relatives. In the prison, the care team and chaplaincy supported the staff who had been involved. Staff and chaplaincy also offered support to prisoners.

THE INVESTIGATION PROCESS

1. The man died in February 2009. Notices were issued to staff and prisoners at the prison to inform them of the investigation process and give them the opportunity to speak with my senior investigator. She visited the HMP Leicester to open the investigation on 10 February. During the visit, she met the Governor, a representative of the Prison Officers' Association and the prison's family liaison officer. The prison provided the man's prison records for examination as well as his medical record.
2. My senior investigator visited the prison twice in April and May 2009 to interview staff. On the first occasion, she conducted the interviews jointly with the clinical reviewer for Leicester Primary Care Trust. On the second occasion she briefed the Governor on her findings.
3. One of my office's own family liaison officers contacted the man's family to give them the opportunity to raise their concerns. They chose to do this via their solicitor who wrote to my office with a number of questions. They asked why the man was transferred to Leicester, whether he had shown signs of wanting to harm himself, and questions relating to the method he used to do so.
4. After the draft report was issued, the family sent my investigator a copy of a complaint form submitted by the man whilst at Nottingham. In the complaint, he names two officers and complains about their treatment of him. He ticked a box on the form to confirm that his complaint had a racial aspect. My investigator took the matter up with managers at Nottingham, who could provide no additional information about the complaint.

HMP LEICESTER

5. HMP Leicester is a local prison for adult males. (Local prisons send and receive prisoners directly to and from the courts.) It has a certified normal accommodation of 206 prisoners and operational capacity (total crowded capacity) of 392.
6. It is a small, old, inner-city prison. The main residential unit is a large, four-storey, early Victorian building. This is divided into a First Night Centre, segregation unit and behaviour improvement landing, a self-contained detoxification landing and vulnerable prisoner unit, and a landing holding prisoners on basic, standard and enhanced status (depending on behaviour).
7. Primary healthcare is commissioned by the Leicester City Primary Care Trust and provided by Serco Health. There is 24 hour cover with a daily GP and weekly visits from a psychiatrist, dentist, physiotherapist, psychologist and sexual health specialist.
8. In my reports into previous deaths at Leicester, I have made several recommendations about improving emergency procedures and CPR attempts that have been accepted by prison and healthcare managers. In this report I repeat a recommendation about health screening in reception.
9. Every prison in England and Wales has an Independent Monitoring Board (IMB). The members are volunteers who monitor the day-to-day life in the prison and ensure that proper standards of care and decency are maintained. The report of HMP Leicester's Independent Monitoring Board that covered the period February 2008 to January 2009 highlighted no concerns relevant to the man's time in the prison.
10. The most recent inspection by HM Chief Inspector of Prisons was an announced full inspection carried out from 2 -6 June 2008. The report concluded:

“HMP Leicester is a small, crowded, Victorian city-centre local prison. It has to manage an ever-changing population of prisoners, many with significant needs, in ageing and inadequate accommodation. Previous inspections have been highly critical of the prison, but on this visit inspectors detected some early signs of improvement, with a greater emphasis on safety and some encouraging developments in resettlement, although much more remained to be done... Efforts had been made to improve violence reduction and safer custody procedures and, although these areas still required a good deal of development, prisoners generally reported feeling safe.”

KEY FINDINGS

HMP Nottingham

11. The man was remanded into custody on 1 October 2008 at Derby Magistrates' Court and taken to HMP Nottingham. It was not his first time in prison. After going through the reception procedures, he went to the First Night Centre, as all prisoners entering Nottingham do. The man did not ask for a drugs detoxification programme on arrival. He told staff he preferred to detoxify himself as this shortened the process. However, he agreed to complete the five-day alcohol detoxification. The following day, he went through the induction process. He told staff that he had no thoughts of self-harm and was aware that Listeners and the Samaritans phone were available. (Listeners are prisoners who have volunteered for the role and have been trained by the Samaritans to provide confidential emotional support to fellow prisoners in distress. The Samaritans phone is a wireless handset that connects only to the Samaritans helpline which prisoners can use in their cell.)
12. The man then moved to F wing, where he settled into the prison routine. On 10 October, wing staff gave him a behaviour warning under the Incentives and Earned Privileges (IEP) scheme. (The scheme is intended to encourage and reward constructive behaviour. There are three levels: basic, standard and enhanced.) He had failed to return to his cell after showering and staff noted in his record that he "displayed a poor attitude" when they spoke to him about it.
13. Two days later, the man went to the healthcare centre as he had an abscess on his arm. A nurse put ointment on the wound and dressed it. Nurses changed the dressing regularly until 20 October when the treatment ended.
14. The man referred himself to the Counselling Assessment Referral Advice and Throughcare (CARATs) team on 3 November. The CARATs team provides drug misuse intervention services in prisons. The man wrote on the application form that he wanted to complete the four-week Short Duration Programme (SDP) and asked for a place on the next course. The course deals with the dangers of drug taking and ways of reducing substance misuse.
15. A week later, a member of the CARATs team, assessed the man's level of substance misuse and his needs. During the CARATs assessment, the man said that he used alcohol, heroin and crack cocaine in the community. He estimated that he spent about £1,000 per week, which he funded by crime. He said that his crimes were serious and increasingly involved violence. He expected to receive up to eight years imprisonment for his latest offences. In the section headed "Summary of personal and social functioning" the member

of the CARATs team wrote, "Very impulsive throughout – no thought given to consequences of his actions." And, referring to the current offences, "...acting without thought for consequences." He concluded that the man would be suitable for the SDP. The man attended the course from 24 November to 19 December.

16. On 20 and 21 November, staff gave the man two further behaviour warnings for not following their instructions. This triggered an IEP board, which was held two days later to review his level of privilege. The man wrote to the board, setting out various personal problems and apologising for his behaviour. In light of this, the board members decided not to downgrade him from standard to basic level but to give him a final warning. When an officer informed the man of the board's decision, he verbally abused the officer. The officer put him on a formal disciplinary report. (When prison staff think a prisoner has broken a Prison Rule, they may put him/her "on report". The prisoner must be told within 48 hours what offence he/she is accused of having committed. A disciplinary hearing, called an adjudication, is then held. If the charge is proved, the adjudicator imposes a penalty.)
17. The governor who heard the case gave the man three days cellular confinement, suspended for two months. (A prisoner can be confined to his cell as a punishment if found guilty at an adjudication. He is located in the segregation unit and spends almost all his time locked in the cell.) The following day, he asked staff if he could move to D wing and share a cell with a friend as he "had a problem with a couple of lads". (However, he did not complain of being bullied to staff).
18. On 23 December, he returned to court where he was convicted. He returned to prison to await sentencing. The following day, staff again placed him on a disciplinary report after he threatened a prisoner and an officer. The hearings were adjourned twice to allow him to call witnesses.
19. The man moved to D wing on 5 January 2009. However, he received two further behaviour warnings and, on 12 January, an IEP board decided to move him to the basic level, which meant that he lost certain privileges. The following day, the two charges from December were heard at an adjudication. He received a total of 14 days cellular confinement. On 23 January, he returned to the wing.

Hostage incident on 27 January

20. Four days later, at approximately 9.00am, a prisoner barricaded his cell door and told staff that he had taken the man hostage. Staff put emergency procedures into place and negotiators spoke to the prisoner through the door. As they did so, they could hear him discussing the situation with the man. After listening for some time, staff decided that he was no longer a hostage

but was working with the other man to make it appear that he was being held against his will.

21. Staff then entered the cell and removed both prisoners, using control and restraint (C&R) procedures. (C&R is the only approved method for staff to restrain prisoners by force. It involves placing physical holds to control the movement of the prisoner. All discipline staff who work with prisoners are required to be trained in C&R techniques.) They were taken to the segregation unit. On arrival, a member of healthcare staff examined the man before completing the report form "Injury to Inmate". The nurse wrote, "On examination at the segregation unit, no visible injuries present, no swelling nor reports of pain." Later that day, the man transferred to HMP Leicester and the other prisoner was sent to HMP Lincoln. The transfer appears to have been arranged so quickly that his property remained at Nottingham. The medical record shows that by 3.43pm he was in Leicester's reception.

HMP Leicester

22. When he arrived at Leicester, the man went through the reception procedures and then to the First Night Centre. Staff placed him on the standard level of the IEP scheme. The following day, as part of his induction, a member of the chaplaincy visited him in his cell. The Imam, introduced himself and spoke with the man for a few minutes. The man asked the Imam for help in getting his property from Nottingham, especially family photographs. He said that he was shortly returning to court and needed his belongings before then. They spoke briefly about the hostage incident and the man said that Nottingham staff were "confused" about which prisoner was the hostage. Finally, he mentioned that his brother was in Lincoln and he wanted to be there too.
23. Also on 28 January, staff at Nottingham faxed adjudication paperwork to Leicester related to the alleged hostage incident. The man was charged with breaking Prison Rule 51, Paragraph 3, "denies access to any part of the prison to any officer..." An officer gave the man a copy of the report form.
24. The following day, the man appeared in front of a governor at adjudication. He pleaded not guilty. In the record of the hearing, the governor wrote that the man said:

"I asked another prisoner if I could help him write a letter, so I went in the cell. The officer locked me in the cell with him. Once I got in the cell he put the drawer in front of the door. He then got a blade out. He got a towel and covered the flap with it and pulled the blade out and he said, 'I haven't got a problem with you but I got a problem with medication and complaints, okay.' The officer came and he let him see me and put a blade to my throat and then he let me sit down and he talked to one of the negotiators. Once they

came to agreement, they said, 'I know you are innocent.' They let me out of the cell. But when the others got there they took the other one out first and then in the afternoon they came and told me I'm coming here."

25. The first part of the statement was confirmed by the other prisoner in a conversation he had with an officer on the way to Lincoln. He said that he had asked the man to write a letter and then barricaded them both in the cell. He told the man that he was holding him hostage to show his dissatisfaction at not being given medication. However, he said that during the incident the man became actively involved in helping him with the plans.
26. Due to the seriousness of the charge, the governor referred it to an independent adjudicator (a district judge who would hold the adjudication at a later date).
27. On 1 February, the man and a prisoner spoke together. After the man's death, a prisoner told an officer that, during their conversation, the man had said, "It's easy to hang yourself in here, isn't it?" It was the other prisoner's first time in prison and he later told staff that he had regarded it as a "flippant" comment and had thought no more about it at the time.

February 2009

28. At 2.00am the man had a brief conversation with his personal officer through the locked cell door. The officer saw that the man was awake and introduced himself as his personal officer. He said that he would speak more fully to him once he was off night duty. There is no record of the man's movements for the rest of the morning.
29. A second officer spoke to the man after lunch. The man said that he was not going to Education that afternoon as he had an appointment with a CARATs worker. His cellmate went to Education. The man asked the officer if he could telephone his solicitor and he replied that he would arrange it once everyone had gone to work or Education. The PIN phone records show that the man telephoned his partner at 1.45pm but there was no reply. (Each prisoner is given a unique personal identification number (PIN) to access their telephone account and they are only able to dial authorised numbers.)
30. At approximately 2.15pm, the drug work who was a member of the CARATs team and the man met in an office on the ground floor of the wing. She reassessed the Comprehensive Substance Misuse Assessment form completed by Nottingham CARATs staff to see the work that had been done and what was outstanding. She discussed the previous entries with him and asked him if his circumstances had changed since completion on 12 November. She added several notes to the form as the meeting progressed.

31. At the start of the meeting, the man asked the drugs worker how long they would be, as he “needed to phone his solicitor”. He did not provide any more details. The drugs worker saw from the man’s records that he had been transferred to Leicester because of a security incident. She began the interview by asking him the reason for his move. She told my investigator that the man had said that:

“... there was a hostage situation with him and his cell mate. They didn’t know who had taken who hostage and therefore transferred them both out.”

He admitted that he had used heroin “a couple of times” whilst at Nottingham. He said that he had “split up with current partner”, although they were still in touch. He had used the drug because of how stressed he was.

32. A number of the questions on the form are about self-harm, both in the past and current thoughts. The drugs worker told my investigator that when she asked about self-harm the man shook his head and said no. She and the man then discussed ways to reduce the dangers of taking drugs and to prevent overdoses. She gave him an information pack to read later in his cell.

33. As the meeting ended, the man asked her how long a sentence she thought he would be given for his offence, as his solicitor had said it could be three years imprisonment. He also asked if she could arrange for him to transfer to HMP Lincoln after being sentenced. She explained that she could not do so. The man also asked if she could help him recover his belongings from Nottingham, including the certificate for completing the SDP. She told him to speak to the wing staff about his possessions and she would ask the Nottingham CARATs staff to send on his certificate. The drugs worker estimated that the meeting finished at around 3.00pm.

34. The drugs worker and the man left the office and the drugs worker went up to level four to tell the second officer that the meeting was finished. The man followed her as far as landing three, where he stopped to talk to a prisoner. The first prisoner told my interviewer that the man said he had just telephoned his partner and they had argued. The prisoner thought that he “seemed a bit irate” about it and gave him some cigarettes. The man asked him if he could get him some Subutex, saying, “My head is done in. I just need something.” The prisoner said that he had refused to help the man obtain Subutex.

35. The man then moved to the neighbouring cell and spoke to a second prisoner, whom he knew in the community. The prisoner gave him a cigarette and they spoke for approximately 10 minutes, mainly about their cases. The man said he wanted to go to Lincoln because that was where his brother was. The prisoner told my investigator that the man appeared fine and showed no sign of wanting to harm himself. The man did not ask the prisoner to help him

obtain drugs. He said he wanted to telephone his solicitor and left the cell. The PIN phone records show that the man did not telephone his solicitor while he was at Leicester.

36. A third prisoner told my investigator that the man had come to his cell door around 3.00pm, asking if he could obtain heroin for him. The man told him that his partner had broken off their relationship. The prisoner told the man that he could not help him obtain drugs.
37. The man then returned to landing four where the second officer asked if he wanted to make his telephone call. The PIN phone records show that the man telephoned his partner at 3.20pm and spoke to her for five minutes. They spoke about the man's offences and the ending of their relationship.
38. At 4.10pm, the prisoners began returning to the wing and staff locked them in their cells. A few minutes later, the first prisoner went to the man's cell to give him some sugar. He looked through the observation hatch and saw the man hanging from the window bars. In shock, he walked away. The first officer on the scene saw the shock on the prisoner's face and started to walk towards him. At that point, about 4.15pm, the cellmate returned from Education and saw that the observation hatch was open, which he regarded as unusual. He looked through and saw the man. He called the second officer, saying, "Boss, take a look."
39. The first officer on the scene looked through the observation hatch. The cell was in darkness, so he turned on the night light and saw the man hanging from the window against the back wall. He entered the cell, shouting to his colleagues for assistance and lifted the man up. A prisoner came and helped him support the man. The window was open, snow was coming into the cell. In interview, the first officer on the scene described the man's face as icy to the touch.
40. The first officer on the scene passed his anti-ligature knife to the prisoner who had come to help him just as the second officer on the scene came in. She took the knife and reached up to try to cut the ligature. The third and fourth officers on the scene were further along the landing when they heard the call for assistance. They thought it came from the level three landing so they went down the stairs. Then they heard the second officer on the scene shout and realised it was on level four. They ran back up the stairs and went into the cell.
41. The third officer on the scene helped support the man while the fourth officer on the scene took out his anti-ligature knife and climbed onto furniture to get up to the window. The bed sheet was tightly twisted like a thick rope and was wound round on itself so that there were no knots. The officer tried to cut the sheet but it was too thick. He asked the others to lift the man higher, which

loosened the ligature enough for him to unwind it. As they were doing this, the general alarm bell on the landing was pressed and an officer called "Code Blue" on his radio. (This code is used when a prisoner is having difficulty breathing or is not breathing. When Code Blue is called, the Communications Room staff always call an emergency ambulance.) The staff lowered the man to the floor and the first officer on the scene and the second officer on the scene and the prisoner who had come to help left the cell.

42. The fourth officer on the scene felt the man's neck for a pulse but could not find one. The third officer on the scene began chest compressions and he and the fourth officer on the scene took turns in doing sets of 30. The first nurse on the scene arrived at 4.23pm and she used a face mask to give the man two breaths after each set of compressions. Other staff cleared the cell of furniture to give them room to work. A second nurse on the scene arrived with the bag of emergency equipment, including oxygen and the defibrillator. The first nurse on the scene used a face mask to give oxygen to the man while the second nurse on the scene set up the defibrillator. (The defibrillator is a machine that treats victims of sudden cardiac arrest by delivering a shock to the heart.)
43. The defibrillator delivered a shock to the man then told the staff to continue with CPR. The second nurse on the scene checked for breathing, a pulse and heartbeat but there was none. The third nurse on the scene entered the cell and took over the chest compressions from the fourth officer on the scene. The defibrillator told the staff to stand clear once again. After assessing the man's condition, it said that no shock would be given. At that point (4.34pm), the paramedics arrived at the cell. The paramedics asked the second nurse on the scene to detach the defibrillator so they could attach their own machine. She did this and left the cell.
44. The third nurse on the scene continued chest compressions while the paramedics set up their equipment and assessed the man. Five minutes later the prison doctor arrived and examined the man. He found no signs of life and certified death at 4.43pm.
45. The Deputy Governor, a chaplain and the Imam, went to the family home that evening and broke the news of the man's death. The Imam subsequently liaised with the Imam at Lincoln who gave the man's brother support and accompanied him to the funeral. The Imam also attended the funeral.
46. The senior officer in the Safer Custody unit reviewed all prisoners who were on open Assessment, Care in Custody and Teamwork (ACCT) plans. (ACCT is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves and implements a plan to give support through a period of crisis.) The Care Team supported staff, and the chaplaincy team

offered support to prisoners over the following days. The Governor wrote to the prisoner, thanking him for the role he played in trying to help the man.

47. Senior managers held a hot debrief to review what had happened. (After a death, prison managers must hold a 'hot debrief'. This is a meeting of all the staff who were involved in finding and attempting to resuscitate the prisoner. The meeting should focus on reassurance, information sharing and how staff can support each other.) All staff were later invited to a critical incident debrief.

ISSUES

Health

48. On arrival at Nottingham, the man told staff that he used heroin, crack cocaine and alcohol. He refused the offer of a detoxification programme for the drugs, telling staff that he preferred to detoxify by himself. However, he accepted the alcohol detoxification programme. The only other significant contact with healthcare staff was for the treatment of an abscess on his arm. A nurse assessed the man in Leicester's reception on 27 January. For the next five days there are no entries in the medical record.
49. The clinical reviewer makes one recommendation about general health matters, specifically the reception health screening. He notes that nurse who did the health screening "... screening appears to have been cursory and the record of it contains two assertions that are at variance with what had been recorded at more in-depth assessments at HMP Nottingham." In a previous clinical review, the clinical reviewer recommended that the nurse's performance should be managed to ensure that he is performing to his full potential.

Complaint by the man against two officers at Nottingham

50. After the man's family received the draft report, they brought to my attention an official complaint he made whilst at Nottingham. A copy of the document is at Annex 16. The man complained that two officers, whom he named, made racist remarks to him. He said, "I would like some action taken from the prison service". The then Deputy Governor responded on the form by saying, "I have asked the Police Liaison Officer to come and interview you in regard to your complaint".
51. My investigator contacted the then Deputy Governor and then wrote twice to the Governor, asking for copies of the records they held about the man's complaint and any action taken. In a letter dated 23 September, the Governor said that their records show only one complaint from the man and enclosed a copy of it. It was dated October 2006. My discussion of the issue is, therefore, based solely on the complaint form supplied by the man's family.
52. The man ticked two boxes on his complaint form, indicating that he regarded the incident as racist. PSO 2800 Race Equality sets out what prison staff should do when they receive a complaint of racist behaviour. Paragraph 6.7 says,

"All complaints of racism received from any source are: Converted to a RIRF [Racist Incident report Form], unless already recorded on one, and a summary of the complaint is recorded on the form"

Paragraph 6.9 states,

“Investigations must be carried out fairly and appropriately, and in a timely manner, in accordance with PSO1300.”

There is no evidence that the man’s complaint was converted into a RIRF or investigated. Neither is there any record of the police interview with the man or the result.

The Governor of Nottingham should remind staff of the requirements of PSO 2800 in dealing with complaints that are flagged as having a racial aspect.

53. The investigator interviewed a number of prisoners and staff and asked about their conversations with the man. Several spoke about issues the man shared with them, including his desire to move to Lincoln. However, no-one mentioned his Nottingham complaint when interviewed. Given that he spoke openly of other issues, he may have spoken of the lack of response to his complaint, if it had been an issue for him. But, from his silence on the subject, it seems reasonable to infer that it was not a major concern for him once he was at Leicester.

Transfer to Leicester

54. The man transferred to Leicester after being involved in a hostage incident. The sequence of events that he related to the governor at adjudication and the one that the other prisoner gave to an officer agree in many details. However, the other prisoner is recorded as saying that the man became a willing participant by helping plan their next actions. At the adjudication, he told the governor that staff accepted his innocence but, once out of the cell, he was treated as being involved.
55. The other prisoner took responsibility for initiating the incident. The man, in offering to help the other man, was caught up in a situation not of his making. However, as the incident went on, staff came to the conclusion that the man was discussing and planning the negotiations with the other man. Rightly therefore, when they took the two men from the cell they regarded them both as having broken Prison Rules. Both were transferred from Nottingham within a few hours of the incident and the following day staff sent adjudication paperwork to Leicester. I am content that on the evidence available to staff, both the man’s transfer and the decision to charge him were appropriate.

Self- harm

56. The man was asked on several occasions during his time in custody whether he currently or ever had thoughts or acts of self-harm. He was asked in

reception and during his CARATs assessment at both prisons. He always replied that he did not.

57. To support prisoners who do have an inclination to harm themselves, prisons use ACCT plans. All members of staff receive training to carry out the ACCT process, including signs to look for and how and when to open a plan. No member of staff had any concerns about the man that would have led to them opening an ACCT.
58. The drugs worker spent approximately 45 minutes with the man in the two hours before his death. She asked him about self-harm as part of the assessment and told my investigator “the man said to me that he had no history and no need to self-harm or no suicidal thoughts at that point as well.” His thoughts were of the future. He spoke about the length of prison sentence he would be given, wanting his property from Nottingham and hoping to move to Lincoln. He also discussed his relationship ending but was happy that he continued to have contact with his partner. The drugs worker said, “I think he was hoping that maybe she would change her mind while they were in contact.”
59. After he returned to the wing, the man spoke to at least three prisoners, asking two of them for drugs. None had any concerns about the man. The first prisoner who saw the man thought he seemed a “bit irate” but not down or at risk of harming himself. The second prisoner who saw the man said, “I didn’t see nothing wrong.” The first officer on the scene then spoke briefly to the man about using the telephone. When asked how the man looked, he said, “nothing that triggered any warning signs. He seemed comfortable, happy - as happy as anyone is in prison. He didn’t look down, he didn’t look depressed, he did make eye contact.”
60. The clinical reviewer, in his clinical review, says that he saw no evidence that the man suffered from depression, psychosis or any other mental health problem. He concludes that:

“I have seen nothing to suggest that the staff at HMP Nottingham or HMP Leicester should have regarded the man’s risk of self-harm as being higher than that of the generality of prisoners.”

Asking for drugs and the telephone call

61. There are two uncertainties about the man’s actions after his interview with the drugs worker. First, although he told her, the first officer on the scene and the second prisoner who saw him that he wanted to telephone his solicitor, he did not do so that afternoon. The PIN phone records show that he did not call his solicitors at any time whilst at Leicester. His call was to his partner and was timed at 3.20pm.

62. This leads to the question of the man asking two prisoners for drugs, both of whom told my investigator that it was because of relationship difficulties. After the meeting with the drugs worker ended, the man returned to the landings and he followed her as far as the third level, where he stopped to talk a prisoner. The drugs worker continued to level four where she spoke to the first officer on the scene. He told my investigator that as the drugs worker spoke to him, he looked down to the third landing and saw the man at the prisoner's cell. There was, therefore no time for the man to have telephoned his partner before speaking to the prisoner. The third prisoner who saw the man spoke to him around 3.00pm, which again would have been before the telephone call.

63. The sequence of events does not tally with the man looking for drugs because he had had an upsetting telephone call. The evidence of the drugs worker and the first officer on the scene shows that the man's conversation with the first prisoner must have been before the phone call. The conversation with the third prisoner was not observed, but the third prisoner's estimate of the time was that it was around 3.00pm, again before the call. I make these observations without comment. I have no explanation for the apparent discrepancies in the man's statements about the person he was going to telephone and the reason for seeking drugs.

The telephone call with the man's partner

64. The man spoke to his partner for five minutes at 3.20pm. As is the case in all prisons, telephone calls can be recorded, and this one was. After the man's death, prison staff transcribed the call and provided a copy of the transcript to my investigator.

65. During the call, the man's partner made a number of statements that appear to show that she was telling the man in no uncertain terms that she was ending their relationship. However, when my family liaison officer discussed the call with her, she said this was not the case. She was very clear that she did not end the relationship during the call. She was equally clear that the man would have understood this. She said that the way she spoke to him on 2 February was the way they always talked to each other. She emphasised that she saw the relationship continuing, as did he.

Staff attempts to resuscitate the man

66. In my reports on previous deaths in Leicester, I have recommended improvements to emergency procedures and equipment which were subsequently implemented. I am pleased to note the clinical reviewer's conclusion that:

“This resuscitation attempt appears to have been well managed. Prison Officers delivered chest compressions until the prompt arrival of Healthcare staff when ventilation was instigated. The correct equipment was brought to the scene and it was used correctly.”

67. The only omission is that the request for help did not include a location. The third and fourth officers on the scene initially thought that the call for assistance came from the third landing so they moved from the fourth to third level. Then the second officer on the scene shouted and they realised that she was on the fourth landing. However, it is clear from their interviews with my investigator and the prisoner’s police statement that they arrived at the cell very quickly. Leicester is a small, compact prison and the distances covered were short. The first officer on the scene and the prisoner were supporting the man’s weight to loosen the ligature. I am satisfied that the confusion over location did not adversely affect the man’s treatment. However, requests for assistance should always include a location.

The Governor should remind all staff to give a location when calling for assistance.

68. The clinical reviewer makes two further recommendations relating to healthcare matters at Leicester. He discusses them in his review, which is at Annex 2. They relate to changes made to the emergency equipment that nurses take to a Code Blue incident after previous deaths at the prison. Previously, the equipment was contained in a number of bags which were difficult to carry to the emergency, especially when having to unlock and relock gates. The equipment is now in one large and heavy bag which presents its own challenges. I repeat the recommendations here:

The Healthcare Manager should examine ways to ensure staff are consulted when changes are being made to working procedures.

The Governor and Healthcare Manager should examine whether further changes can be made to make it easier to take the emergency equipment to an incident.

Conclusion

69. The man was a young man who was awaiting sentencing for a serious offence. He told prison staff that he was expecting up to eight years imprisonment. He also said that his relationship with his partner had ended. On the afternoon of 2 February, after his interview with a CARATs worker, he spoke to a number of prisoners, some of whom he asked for drugs. He telephoned his partner and they spoke for five minutes about the offences and their relationship. He then returned to his cell and took the actions that

led to his death. During his time in prison, he had told various members of staff about problems he was experiencing. However, from the available evidence, at no time did he suggest he was suicidal or show any signs that he needed additional help or support. Neither did he leave any letters to explain his actions.

70. I am entirely satisfied that staff could not have foreseen the man's actions and that when he was found they acted promptly and appropriately.

RECOMMENDATIONS

1. The Governor should remind all staff to give a location when calling for assistance.
2. The Healthcare Manager should examine ways to ensure staff are consulted when changes are being made to working procedures.
4. The Governor and Healthcare Manager should examine whether further changes can be made to make it easier to take the emergency equipment to an incident.
5. The Governor of Nottingham should remind staff of the requirements of PSO 2800 in dealing with complaints that are flagged as having a racial aspect.