The circumstances surrounding the death of a man at

HMP Highpoint in March 2007

Report by the Prisons and Probation Ombudsman for England and Wales

November 2007

This is the report of an investigation into the death of a man at Highpoint prison in March 2007. At about 4.25pm that day, he was found hanging in his cell.

The man was from Poland and had been separated from his family by hundreds of miles since he first came to England to find work in 2005. I know that the news of his death came as a severe shock to his wife who loved him deeply, and who found the separation extremely difficult. She had no idea that her husband was contemplating suicide.

The investigation was carried out by my colleague. I also commissioned an independent clinical review of the management of the man's healthcare needs while he was in prison custody. This was conducted by a representative of the Suffolk Primary Care Trust (PCT). I am grateful to the PCT for his work.

I should also like to thank the Governor of Highpoint prison and her staff for their help and co-operation during the investigation.

The investigation found that the man's death was entirely unpredictable. There was little staff at Highpoint could have done to prevent it. I commend the actions of three members of staff and two prisoners who were involved in attempts to save his life. I congratulate the Governor for her leadership and personal involvement during the emergency and in the aftermath of the man's death.

I intend no criticism whatsoever of the author of the clinical review, nor of the Primary Care Trust whose practice is in line with that applied following serious incidents. However, I should say that I personally believe that clinical reviews should not be commissioned from those directly responsible for the delivery of healthcare in the prison concerned. I draw this to the attention of those in the Department of Health responsible for prison healthcare.

I have made no recommendations. However, I trust the Governor will respond appropriately to my comments on those members of staff and prisoners who should be commended. In addition, I trust that the Prison Service's Area Manager for the Eastern Area will note my comments on the Governor's own actions and conspicuous leadership.

Stephen Shaw CBE **November 2007**
Prisons and Probation Ombudsman

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SUMMARY

The man was born in Poland in March 1978. He had an unhappy childhood and turned to crime at an early age. He took to drugs and became involved in robberies. In 2005, he came to England to find work but soon returned to crime. One day, whilst apparently under the influence of drugs, he burgled a house unaware of the presence of the owner, a young woman. She caught him, in a state of panic, he attempted to strangle her. The man fled the scene and returned to Poland. In July 2005, he met the woman who was to become his wife. In September that year they married. The man was eventually arrested and extradited to England to face trial.

The man appeared in court in August 2006 accused of attempted murder. He was remanded in custody at Peterborough prison. In September, he was transferred to Norwich prison. Whilst there, he was taken to Cambridge Crown Court for trial. In November, he was sentenced to 116 months imprisonment but three days later this was varied to 8 years. He was also recommended for deportation at the end of his sentence.

On 14 December, the man was transferred from Norwich prison to Highpoint, a Category C prison in Suffolk. Here he soon appeared to settle, mixing with a few other prisoners, including another Polish man who became his best friend. Although the man's command of the English language was limited, he was able to communicate well with the help of his new found friend.

Towards the end of 2006, the man's wife visited him on two occasions. In order to pay for her visits to England, she had taken out loans which she could ill afford. In March 2007, the man made numerous calls to her. He confided to another prisoner that he was worried about whether their relationship could survive his lengthy sentence. His phone calls became increasingly frequent, almost obsessive.

On the day he died, the man told staff on his wing his mother had been taken into hospital in Poland. They saw he was very distressed and asked the Chaplain to see him. With the authority of a senior manager, the Chaplain arranged for the man to telephone his wife from the chapel at public expense. The call lasted 25 minutes. Afterwards, the Chaplain took the man back to his wing. He and other staff in the wing did not notice anything untoward in the man's demeanour. However, the man later called his wife again from a telephone in the wing. Although the call was recorded, it was not supervised. He kept asking his wife if she was alright, and was clearly anxious about their relationship, but at no stage did he say anything that could have been interpreted as a sign that he was contemplating suicide. He retuned to his cell some time after 3pm. No-one in the wing saw any signs of what was to come.

At 4:30pm, the man was found hanging in his cell by an officer. Despite strenuous efforts by healthcare staff and paramedics to revive him, he was pronounced dead in his cell at 4:55pm.

At about 9:30 that evening, a Polish priest known to the Roman Catholic Chaplain at Highpoint telephoned the man's wife to inform her of his death. She was very shocked and distressed. She said she had no idea her husband was contemplating taking his own life. Later, the family asked for the man's body to be repatriated. This took place on 20 April. The Governor met the full costs and paid for his funeral.

At no stage during his time at Peterborough, Norwich and Highpoint prisons did the man display any signs that he was at risk of suicide. He had no apparent mental health problems and seemed to cope with his imprisonment. He attended Mass regularly and talked to the Roman Catholic priest quite openly. The priest and the discipline staff regarded him as a polite and cooperative man with no obvious problems. The investigation found no evidence that the man was disadvantaged or isolated because of his status as a foreign national.

I draw the conclusion that the man's death was neither predictable nor preventable.

I am especially heartened by the findings of my investigator that the staff who responded to the discovery of the man hanging did so with the highest standards of professionalism, compassion and dignity. I commend three members of staff in particular, as well as two prisoners, for the manner in which they conducted themselves in attempting to save his life. I also congratulate the Governor for the manner in which she so readily and ably arranged for the repatriation of the man's body to his loved ones in Poland and continued to support the family thereafter.

I make no recommendations.

INVESTIGATION PROCESS

The investigation was opened two days after the man's death when my investigator met with the Governor, a representative of the Prison Officers' Association and a representative of the local Independent Monitoring Board. My investigator explained to them the nature and scope of the investigation and the report handling procedures. He returned to Highpoint on 30 April to commence the investigation proper. On that day, notices were issued to staff and to prisoners announcing the investigation and inviting anyone with information about the man's death to come forward. Nine members of staff and three prisoners, one of whom is Polish, were interviewed.

I also commissioned an independent clinical review of the management of the man's health needs while he was in prison custody. This was conducted by a representative of the Suffolk Primary Care Trust.

One of my Family Liaison Officers made contact with the man's wife in order to offer her the opportunity to express any concerns she may have wanted the investigation to explore. In a letter she wrote to my Family Liaison Officer, the man's wife said she was full of praise for people working in prisons in England as she had visited her husband twice. She expressed no issues for the investigation to address but did raise two questions on other matters that have been answered in correspondence from my Family Liaison Officer.

HMP HIGHPOINT

Highpoint is a Category C training prison situated near Haverhill in Suffolk. It can hold up to 816 male adult sentenced offenders.

The accommodation comprises eight living units, all of which are purpose built. In-cell television is available to all prisoners except those on the basic regime.

The prison was last inspected by Her Majesty's Chief Inspector of Prisons in December 2004. In her report of that inspection, the Chief Inspector commented that Highpoint continued to offer a generally safe environment for prisoners and staff. Since the previous inspection that had taken place in September 2002, prisoners' boredom had been reduced, their expectations had been more effectively met and there was more engagement between prisoners and staff. A further inspection took place very soon after this investigation was completed. The report of that inspection has yet to be published.

The report of the 2002 inspection contained a recommendation that the needs of the foreign national population should be addressed. When the Chief Inspector returned in December 2004, she found there were about 200 foreign national prisoners at Highpoint. The report of that inspection commented that their needs were being addressed. However, there was no separate foreign nationals committee and the race relations management committee showed that foreign nationals were only discussed sporadically. The Chief Inspector recommended that a separate foreign national committee should be established with direct prisoner input. The investigation into the man's death found that this recommendation had been implemented. There were no other concerns or recommendations in the Chief Inspector's report relevant to this investigation.

In their annual report on Highpoint for 2006, the local Independent Monitoring Board drew attention to their concern about "the perceived lack of resources available to operate the prison and the problems facing foreign prisoners". Where foreign national prisoners were concerned, the Board was concerned that a number of them were being held in prison beyond their due release date without a further full judicial process. The Board also commented that "suicide and self-harm had continued to be managed very efficiently during the year". The Board thought that staff showed great care and consideration to those considered to be at risk of self-harm. The report contained no matters of concern or recommendations relevant to this investigation.

KEY EVENTS

Arrest, appearance in court and remand in custody

The man appeared at Wisbech Magistrates Court on 23 August 2006, charged with attempted murder of a woman, burglary with violence and causing actual bodily harm. He was remanded in custody at Peterborough prison, and ordered to appear in due course at Cambridge Crown Court for trial. The Prisoner Escort Report (PER) for the journey between Wisbech police station and the Magistrates Court carried no notation of any risk of self-harm. This was the man's first experience of an English prison.

Peterborough prison: 23 August - 8 September 2006

First reception health screen

Upon his arrival at Peterborough prison that day, the man underwent a first reception health screen. He was described as looking "fit and well".
He said he consumed 20 units of alcohol a week and, more than six months earlier, had taken amphetamines. He was described as emotionally calm and fit for normal location (in other words in a residential wing rather than the healthcare centre or separation unit). There were no concerns about his mental state.

Cell sharing risk assessment

As a normal feature of the reception procedures, the man underwent a cell sharing risk assessment. This is a system by which a prisoner's likelihood of harming others is measured. The man was considered to present a high risk of harming others because of the nature of his offence. It was therefore decided that he should not be allowed to share a cell with another prisoner. However, he asked to be separated from other prisoners because of the nature of his offence, the details of which had attracted widespread publicity. This was authorised straightaway and he was allocated a single cell in the Care and Separation Unit.

As he had been charged with attempted murder, a case was submitted to Prison Service Headquarters for him to be classified as a category A (or high security) prisoner. However, he was not so categorised. In fact, he was later made a category C prisoner and allocated to Highpoint prison.

On 25 August, the man was taken from Peterborough prison to Cambridge Crown Court. The PER for the journey to and from court carried no notation of any risk of self-harm.

Entries made in the man's core prison record on 26 and 30 August show that he was regarded as a quiet and compliant prisoner. He was given information about the prison in his own language.

On 4 September, the man declined to take exercise, have a shower or benefit from a phone call. However an entry made in his record that day shows that he did not have any problems.

Norwich: 8 September - 14 December 2006

On 8 September 2006, the man was transferred from Peterborough prison to Norwich. He left Peterborough at 12:45pm and arrived at Norwich at 4:25pm. The PER for the journey carried no notation of any risk of self-harm.

The following entry was made in his medical record that day:

> "Seen in reception transfer in from HMP Peterborough speaks very little English. States he is on sleeping pills according to the chart these have now stopped.. Wants to see Dr for sleep problems has been in the past on Phenegan 25mg nocte. Appears fit and well denies any self harm feelings. To see Dr (tomorrow)."

The man's core prison record shows he was visited by his wife on 16 October and 4 December. There is no information in his record to show how he coped with each visit.

On 24 November 2006, the man was sentenced at Cambridge Crown Court to 116 months imprisonment. On 27 November, his sentence was varied to 8 years. He was due to be released in December 2011. He was also made the subject of an order for deportation. The PER for the journey to and from the court carried no notation of any risk of suicide or self-harm.

Highpoint prison: 14 December 2006 - March 2007

On 14 December, the man was transferred to Highpoint. Once again, no notation of any risk of self-harm was included in the PER for the journey between the two prisons.

On 15 December, the man signed his prison compact. This agreement is normally signed by all prisoners. It requires each prisoner to abide by certain rules and explains what privileges can be earned through compliance. It also sets out what each prisoner can reasonably expect of the establishment.

The author of the clinical review of the management of the man's health needs while he was in prison, found that there were no significant changes in his health upon his arrival at Highpoint. The reception screening process revealed no new condition or any symptoms of a physical or psychiatric nature. The man was described as fit and healthy. He was located in cell G1-22 in the First Night Centre. Thereafter, he was initially located in South 4 Unit.

An entry made in the man's record on 3 January shows he was regarded as a "good, polite prisoner" who rarely came to the attention of staff. He was unemployed and on the standard level of privileges. He was described as compliant. On 4 January, he was moved to South 5 Unit in K-3, a single cell.

Throughout the remainder of his time at Highpoint, the man was consistently described as polite, mature and compliant. He seemed to get on well with staff and other prisoners. He befriended another Polish prisoner who speaks English very well. The investigation found no evidence to suggest that the man was in any way isolated or disadvantaged by the fact that he was Polish.

On 25 February, the man's good behaviour was such that he was regarded as worthy of consideration for enhanced privileges. However, his record does not make clear whether he achieved this level before he died. He regularly attended Mass where he could speak freely with a Roman Catholic priest who speaks Polish.

About a week before the man died, he rang his wife twice shortly before midday. One call lasted a little over eight minutes. The other lasted nearly five minutes. The next day, he rang his wife on four occasions between 8am and shortly after midday. The first call was terminated before the receiver was picked up by his wife. The other three calls were very short. There is no information in his record to indicate what state of mind he was in before or after any of these calls.

On the day before he died, the man attempted on 15 occasions to call his wife in Poland. His first attempt was made at 11:43am and the last at 7:58pm. The records show that each call was extremely short.

At about 10:55am on the morning that the man died, a member of staff in Unit 5 called the Chaplaincy office to alert the Chaplain that the man was very upset. The call was taken by the Chaplaincy administrative assistant. She informed the Chaplain, who went to see the man in his cell. When the Chaplain arrived, the man was sitting on his bed with the light off. The Chaplain switched the light on with his agreement. The Chaplain noticed that the man had been crying. He told the Chaplain his wife had just told him on the phone that his mother was in hospital. The telephone conversation ended prematurely because his wife was cut off. He told the Chaplain that he wanted £5 transferred to his pin-phone account so that he could phone his family.

At interview, the Chaplain explained that there was then a short gap in his conversation with the man. Afterwards, the man said he wanted to speak to his Polish friend in Unit 5, when he came back into the unit from work. The Chaplain told him that, in the meantime, he would make enquiries about transferring £5 into his pin-phone account. The man asked if this could be done that day. The Chaplain gave no guarantees, but said he would let him know what would happen. He left the man's cell at about 11:15am.

The Chaplain then spoke to an officer about the possibility of transferring the money. The officer suggested it might be more appropriate to allow the man to make a call at public expense. The suggestion was put to a governor who gave his authorisation.

It was now lunch time in the unit. Afterwards, the Chaplain returned to see the man in his cell. The Chaplain saw that the man had been crying once again. He invited the man to accompany him to the chapel so that he could telephone his family from there. The man was not expecting this and expressed his concern to have some money transferred to his account. The Chaplain reiterated his offer to take him to the chapel and explained to him that the question of transferring funds to his account could be resolved later. The man agreed.

On arrival in the chapel, the Chaplain asked the man to write down the number for him to ring. He wrote down three numbers so that if one did not work, other numbers could be tried. The Chaplain dialled the first number and handed the phone to the man. The call was answered. As the man spoke in Polish, the Chaplain could not understand what was said. However, he noticed that the man's tone was not what he expected. He thought there would be questions and gaps while the man listened for answers. Instead, the man did most of the talking. The Chaplain told my investigator he regarded the man's tone as quiet but assertive rather than enquiring, unemotional and rather flat, almost as if he was trying to explain something.

After 25 minutes, the Chaplain asked the man to bring the conversation to an end. He then made him a cup of coffee. As they left the chapel, the Chaplain wondered how the man's wife would be able to communicate any further news to him about his mother. He asked the man whether his wife had the telephone number of the prison. The Chaplain suggested the man's wife need only to call the chaplaincy number and ask for her husband by name. Thus, any messages could be passed to him. The Chaplain told him that, provided he had some money in his account, he would be able to call his wife. The Chaplain then dialled the number for the man's wife once again, and this time he told her how to call him and what to say. The Chaplain told my investigator the man seemed comforted by that.

The Chaplain recalled that he and the man returned to the unit at about 3pm. The Chaplain spoke to a Principal Officer who arranged for funds to be transferred to the man's pin-phone account straightaway. The man was told the transaction would be completed either that afternoon or the following morning. The Chaplain thought the man was content with the outcome. He left the unit at about 3:15pm.

A little later, the man was seen by an officer walking past the unit office on his way back to his cell. At interview, the officer explained that although he could remember seeing the man, he could not recall his demeanour.

Another officer on duty in Unit 5 during that afternoon recalled taking the man to his cell at about 3:30pm, once the Chaplain had left. The officer left the

man's cell door unlocked in case he wanted to make further telephone calls. At some stage, the man called his wife again, using the telephone available to prisoners. He then returned to his cell. The officer told my investigator that at no time did the man give any impression that he was contemplating taking his life. He said the man seemed happy when he returned to his cell at about 3:30pm.

However a record of calls made by the man that day shows that he phoned his wife on 13 occasions between 8:10am and 3:52pm that day. Most of the calls were very brief indeed, lasting for only a few seconds. The last two calls he made were at 3:27pm and 3:52pm. The first call lasted nearly eight minutes. The second, and final call lasted just over six minutes. The fact that the man called at these times means that he must have left his cell after the officer had left him. My investigator was unable to identify anyone in the wing who saw him do so.

Discovery of the man hanging

An officer explained that on weekday afternoons, prisoners in Unit 5 would normally have to return to their cells after work in time for the tea time roll check at about 4:30pm. At about that time, he and his colleague began to lock up all the prisoners for whom they were responsible. The officer approached the cell occupied by the man. When he looked through the observation panel in the cell door, he saw the man hanging by a ligature from a bracket in the wall designed to hold a notice board. The ligature was fashioned from a bootlace he had used to secure his cell privacy key to his person.

The officer immediately entered the cell, calling for assistance on his radio and shouting to his colleagues as he did so. The officer found himself unable to take the man's weight and cut the ligature away at the same time. A number of prisoners therefore assisted him. The officer could not recall who they were. Between them, they removed the man from his suspended position to his bed. He then removed the ligature from around the man's neck. He did not require a ligature knife to do so. He said that as soon as the ligature had been removed, the man's face immediately turned blue. His tongue protruded from his mouth. He had urinated. The officer thought he felt a pulse and said so to his colleague who felt for a pulse in the man's groin area. He, too; thought he could detect a pulse. However, at interview, both officers admitted that they might have been wrong.

In response to the call for assistance over the radio, the communications room issued a "Code Blue" alert. By this means, all staff carrying radios are alerted to a life-threatening situation in which breathing is threatened or has been lost. The first person to arrive at the cell in response to the emergency call was a Senior Officer. On his arrival, he placed a respiratory mouthpiece over the man's face. Between them, he and a colleague then commenced cardio-pulmonary resuscitation (CPR).

A Staff Nurse and a Nursing Sister were on duty in the healthcare centre at the time. The prison doctor was in their vicinity and also heard the Code Blue message on the radio. He immediately left the healthcare centre and ran to Unit 5. At interview, the doctor estimated that it took him about a minute to reach the unit. He was quickly followed by his colleagues who, between them, carried emergency medical equipment to the cell. Each of these staff told my investigator that on their way to the unit, all gates were open and staff were in place to guide them quickly to the man's cell. Although they were not aware of precisely what had happened, they all guessed they were being called to a possible hanging. They did not know who the casualty was until they arrived at the cell.

When the doctor arrived, he saw staff applying CPR. His initial assessment was that there was no carotid output, the man was cyanosed (his face and lips were blue), and he had urinated. He asked the officers to carry the man to the landing outside the cell where there was more room. On examining him, the doctor found he had no pulse, he was making no respiratory effort, and had dilated, unresponsive pupils. The doctor fixed defibrillator pads to the man's chest. The defibrillator found no shockable rhythm. The nurse commenced chest compressions while a colleague maintained the man's airway.

Other nursing and medical staff also responded to the emergency call and assisted with CPR in rotation. These procedures were maintained for about 25 minutes when a paramedic crew arrived at the cell. (The patient report form completed by the East Anglia Ambulance Service shows that an ambulance was called at 4:37pm and that the ambulance arrived at Highpoint at 4:51pm.)

After that period, the doctor, together with his nursing colleagues and the paramedic crew, decided the resuscitation attempts should cease. Death was pronounced at 4:55pm. The doctor made a full record of these events and decisions in the man's medical record. His concluding remarks were "May he rest in peace".

The man's body was returned to his cell and laid on his bed. A member of staff covered his body and closed his eyes. A priest anointed him and said prayers in his company. The man's body was later taken to the mortuary at West Suffolk Hospital. As his relatives were not residents of the United Kingdom, arrangements were made for the formal identification of his body by a member of staff at Highpoint prison,

At about 5:30pm, the Duty Governor of the day convened a debrief of those staff who had been directly involved in responding to the emergency. The purpose of the meeting was to offer care and support where needed. Without exception, all those who my investigator interviewed reported that the care they were given by the Governor, her senior managers and members of the prison's care team, was excellent.

Informing and supporting the next of kin

As the man's religious denomination was Roman Catholic, the Chaplain the asked the Roman Catholic priest to come into the prison. The priest arranged for a Polish priest to inform the man's next of kin over the telephone. He did so at about 9:30pm that day in the Governor's office. The man's wife was told that her husband had died earlier in the day and it was believed he had taken his own life. She was very distressed. She told the priest that when she spoke to her husband earlier that day, he had said nothing to suggest he was contemplating suicide.

Some days after the man's death, his family asked for his body to be repatriated. The Governor made arrangements for this to happen. His body was flown to Poland on 20 April. The costs were paid by the Governor. At the time of the investigation, the man's personal effects had not been returned to the family, but the Governor assured my investigator that this was in hand and that she would pay any expenses incurred.

ISSUES

Here I consider:

- whether the man's health needs were met while he was in prison custody.
- whether his risk of suicide was properly assessed, managed and monitored.
- whether the response to the discovery of him hanging in his cell was appropriate and effective.
- whether appropriate courtesies and support were extended to this family in the aftermath of his death.

Were the man's health needs met while he was in prison custody?

The author of the independent clinical review of the management of the man's health needs while he was in custody notes that there were no major medical or physical problems evident before the man transferred to Highpoint. There was no history of anxiety or depression or of any contact with mental health services in the United Kingdom or Poland. Neither was there any history of self-harm or attempted suicide. There was no significant history of hard core narcotics or alcohol abuse, although the man admitted on reception at Peterborough that he had taken amphetamines six months before his imprisonment.

The author also reports that there was no significant change during the man's time at Highpoint. He remained fit and healthy. The author comments that the man did not request any other primary care services such as dentist or primary mental health during his time at Highpoint. He did not require any input from secondary /tertiary and/or specialist services.

The author concludes that from the date of transfer to Highpoint, the man was offered all relevant primary care services comparable to those available in the community.

I agree with these conclusions.

Was the man's risk of suicide properly assessed, managed and monitored?

On entry into prison on 23 August 2006, the man gave no indication of being at risk of suicide, despite the fact that this was apparently his first time in prison and he had committed an offence that would inevitably attract a long prison sentence. Neither did he manifest any such risk thereafter. Staff had no reason to believe he was contemplating suicide.

However, the investigation found the man was extremely concerned about his relationship with his wife. It became clear that the strain of being separated in another country and having to cope with a long sentence of imprisonment took its toll on both partners. As a result, he made a number of calls to his wife. Several of his attempts to talk to her failed either because there was no

reply or because one or the other of them hung up prematurely. The man's anxiety at this time was obvious. When staff noticed his distress, they asked the Chaplain to intervene. The man told the Chaplain his mother had been rushed into hospital and wanted to phone his wife to find out what had happened. The Chaplain responded by supervising a long telephone call between the man and his wife. The Chaplain was not to know that the man used the call to seek reassurances from his wife about their relationship rather than to find out about his mother.

Although the Chaplain could sense the man's anxiety from the tone of his conversation, he was given no indication of what was to come later that day. Later, the man made two more calls to his wife. My investigator was given a tape recording of those calls. The transcriptions were translated into English. These revealed that although the man was clearly worried about his relationship with his wife, he gave no indication to her that he was contemplating suicide.

Was the response to the discovery of the man hanging appropriate and effective?

The author of the clinical review comments that there was a very prompt response from healthcare and discipline staff when the man was found hanging. He thought this was a good example of joint working between PCT and Prison Service staff. He says that CPR was applied according to UK Resuscitation Guidelines. I agree with his findings.

I am impressed by the professional manner in which those staff who responded to the emergency conducted themselves. They are all worthy of praise. However, I draw particular attention to the actions of three members of staff as well as to those of two prisoners.

I turn first to the Healthcare Manager. Despite the fact that there were adequate staff on duty in the healthcare centre to respond to the emergency, the manager gave her personal assistance in the cell, leading and supporting her staff throughout. After the man was pronounced dead, she closed his eyes and covered his body lending appropriate dignity to the tragedy. In my judgement, these were acts of true professionalism for which the Healthcare Manager should be commended.

I also commend the doctor for the manner in which he co-ordinated activities during the emergency. His cool and collected manner commanded the respect of all the staff who were involved.

The officer who found the man hanging had the presence of mind to comfort the man's best friend when he learned that the man had died. The officer did so in spite of his own severe distress. I commend him for his actions.

The officer said a number of prisoners helped him take the man's weight so that the ligature could be freed. He could only remember two of the prisoners'

names. I commend both prisoners, and any others involved but not named, for their actions in coming to the assistance of staff.

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

The investigation found that effective arrangements were put in place to inform the man's wife very quickly after his death had been pronounced. This, despite the fact that she lives in Poland. Some days after the man's death, his family asked for his body to be repatriated. The Governor made arrangements for this to happen. The body was flown to Poland on 20 April. The costs were paid by the Governor, as were those of the man's funeral. I congratulate the Governor for her leadership and personal involvement during the emergency and in the aftermath of the man's death.

Points of concern raised by the man' wife

Why was the man not repatriated to Poland so that he could serve his prison sentence near his family?

Prisoners in England who wish to be transferred to their native country to serve their sentence near their family are required to apply to be considered for repatriation. The investigation found no evidence that the man asked to be repatriated. Neither was there any documentation in his prison file relating to the issue of repatriation that might have been raised during the extradition proceedings in Poland when he was arrested.

Sadly, we shall never know whether the man knew of the procedures for applying for repatriation.

Was the man's death preventable?

The man's wife understandably believes that her husband's death could have been prevented. She has revealed that in his letters to her he described himself as very depressed. However, as the report shows, at no stage did he give any indications to staff at Highpoint that he was contemplating suicide. Thus, I draw the conclusion that his death could not reasonably have been predicted or prevented.

RECOMMENDATIONS

I make no recommendations. However, I draw attention to my commendations of management, staff and prisoners on pages 16 and 17 above.