

The death in custody of a man  
at HM Prison Swaleside in January 2005

Report by the Prisons and Probation Ombudsman  
for England and Wales

January 2006

This is the report of an investigation into the circumstances surrounding the death of a man at HM Prison Swaleside in January 2005. He was found dead in his cell at 6.55am. A bed sheet had been fashioned into a noose and was wrapped tightly around his neck.

A post mortem examination performed on 13 January at Medway Maritime Hospital found that the cause of death was suspension.

I offer my sincere sympathy and condolences to the family of the man who have suffered the tragic loss of a much loved and important member of their family. The staff at Swaleside shared the sense of loss. They knew him well and remember him with affection.

Mr Ron Tasker, assisted by Mr Tom Wright, carried out the investigation on my behalf. As part of their investigation they commissioned an independent review into the clinical management of the man. I am grateful to Dr Stephen Lawrence who carried out the review on behalf of the Medway Primary Care Trust.

My thanks also go to the Governor and all Swaleside staff. I appreciate their willing cooperation, which has enabled the investigation to be both thorough and to be completed in a timely fashion.

The man's continued use of drugs in prison was likely to have influenced the Parole Board's consideration of his possible release or moves to less secure accommodation. The man was also concerned about his son's health and had told his sister he was in debt to a fellow prisoner to the tune of £120. However, what was actually on his mind at the time of his death is necessarily unknowable. He had given no indication either to staff or to his fellow prisoners of any intention of taking his own life.

I make two recommendations.

In deference to the views of the man's family, I have edited out significant parts of my original report. As a consequence, this anonymised report is much shorter and much less detailed than is my normal practice.

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

**September 2007**

## Summary

The man was born in July 1967. His early life was straightforward and he left school with a good set of examination results. At the time of his death the man had two children.

The man arrived at Swaleside in September 2001. He was serving a life sentence imposed in October 2000 for offences of wounding. A short tariff of three-and-a-half years gives some indication of the trial judge's anxiety and hope. Anxiety because drugs had played a part in the offences, and hope that the man would seek help in prison and be able in the near future to be drug-free and secure his early release.

Apart from periodic temporary transfers to other prisons nearer home to receive visits from his family, the man had been continuously at Swaleside where he was well known and liked by staff and prisoners.

Progress through the prison sentence had been variable. On the one hand the man was a good all round member of the prison community. He chose his friends carefully and worked hard in the prison wing or the workshops. He had completed successfully social skills and other courses. He had enrolled and attended drugs courses and he had subjected himself to voluntary drug testing. On the other hand, the man's drug use continued throughout his sentence and despite his best efforts he was unable to kick the habit. This drug use led the Parole Board in April 2004 to defer a decision on his future. Although the Board marked some progress, they hoped to see a sustained drug free period by the time of the next hearing which was set for March 2005.

At the time of his death, the man had two recent positive findings for drug use. He would have been worried that the parole hearing scheduled for March would take a poor view of this. Furthermore, he had told his sister that he was in debt to another prisoner as a result of borrowing a mobile phone which had been smuggled into the prison. It is probable also that he was worried in respect of his elder son's undiagnosed illness.

The man was in good health and the clinical review revealed a fit young man whose minor ailments from time to time had been treated appropriately. There was no history of depression and to all intents and purposes he was in good health and in good spirits. The man had not previously harmed himself and his demeanour in the period leading to his death appeared normal. Staff could not possibly have seen this coming. As our investigation took shape their shock and disbelief spoke for itself.

It is impossible to say what the man's intentions were when he wrapped a bed sheet round his neck or what motivated his actions. In spite of Swaleside's excellent facilities

to help people with drugs problems, and notwithstanding the man's own very creditable efforts, it may be that he decided the problems were too big for him to solve.

## **Investigation methodology**

The investigation was opened on 12 February 2005 when Mr Tasker and Mr Wright met with the Governor and his deputy at Swaleside. They were given a comprehensive and very helpful briefing on the events leading up to and after the man's death.

Ombudsman's notices were issued to staff and prisoners, identifying the scope of the investigation and inviting anyone who wished to see the investigators to make themselves known. Staff and prisoners in key positions or locations were identified and were invited for interview. All responded willingly and fully. The local branch of the Prison Officers' Association were briefed. They were helpful and offered constructive comment and advice.

Local police were contacted and provided all the information at their disposal, as did the coroner's officer.

The chair of the Independent Monitoring Board was interviewed, as was one other member of the Board.

The investigators commissioned an independent clinical review. Dr Stephen Lawrence conducted this on behalf of Medway Primary Care Trust.

Mr Tasker, together with my family liaison officer, Lucy Phelan, met the man's family at home. They were made to feel very welcome and his mother added a great deal to their knowledge and understanding.

## **Conclusions**

The man could not break free from the drug habit which had direct relevance to the offence for which he had received his life sentence. He would have known that the forthcoming parole review would hear evidence of his current drug taking, and that the Parole Board might say they were unable to note any significant progress over the last year. The man may have thought that release was as far away as ever.

Life had become further complicated through worry about the health of his son. Problems are often magnified in prison and, despite regular information and reassurance from his family, he may have imagined all sorts of things which he could not help sort out.

It also seems that he was in debt to another prisoner. He told his sister that he owed £120 for the use of an unauthorised mobile phone, and he had no way to pay back the money.

When Mr Tasker and Ms Phelan met the family they said they knew that the man was worried about the health of one of his sons, and that he owed money to another prisoner. But they considered it unlikely that these things would have troubled him to the extent that he would want to take his own life.

However, all of this is in the realms of speculation. The man had given no indication that he might harm himself and we cannot know what was in his mind when he attached a ligature around his neck. In the end the problems may have been too big for him to solve, even with the support of his family, staff and fellow prisoners.

## **Recommendations**

The Governor should arrange for notices in foreign languages to be posted in prisoners' telephone booths to advise non-English speaking prisoners how to contact the Samaritans.

In the light of the family's experience, the Governor should remind staff of the importance of returning personal effects to next of kin in a timely and considerate manner.

*It is pleasing to know that the Area Manager and Governor accepted and agreed to implement the two recommendations at the time of the draft report, rather than waiting for the final report.*

## **Good practice**

My investigators highlighted two areas of good practice at Swaleside:

The care team has refurbished an old building in the grounds of the prison. They have spent wisely, and have bought carpets, soft furnishings and paintings, and they have made a small kitchen. The area is used for counseling, for informal conversations and for time out for staff that are, for any reason, feeling low. The care team is proud of their work. Most of them are veterans of many years and events. The team does not confine its activities to working within an office. They are present throughout the prison, on telephones and they visit staff at home. This example of good practice is one that others might emulate. My investigators are aware that many prisons have good care teams. The one at Swaleside, in their view, stands out as the best.

A monthly bulletin is published in the prison. It provides a regular summary of the prison's activity and it highlights how the prison and its population are performing. It describes each wing and identifies both good things about the establishment and things causing anxiety. This easy to read digest is an example of good practice.