

**INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE
DEATH OF**

A MAN AT HMP PRESTON IN MARCH 2005

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

November 2005

The man died whilst a prisoner at HMP Preston in March 2005. He was found hanging in a cell in Preston's Care and Separation Unit (Segregation Unit) just after lunchtime. This is the report of an investigation into the man's death.

I wish to offer my sincere sympathy and condolences to the man's family and friends for their loss. I know that the staff and prisoners at Preston who knew him share those sentiments.

Two of my colleagues undertook the investigation. One of my family liaison officers has maintained contact with the man's family.

I wish to extend my thanks to the Governor and his staff at Preston for their help and co-operation during this investigation. I am also grateful to the clinical reviewer from Preston Primary Care Trust, for instigating a clinical review of the man's care.

The death of this man was one of an alarming number of apparently self inflicted deaths to have occurred in a segregation unit in the past year. In this case, the man had given absolutely no indication that he might have been at risk. However I note that he was completing his detoxification. I also note that there was only one member of staff on duty in the segregation unit at the time he died, but the cell was subject to CCTV coverage. The man's death, at a particularly young age, is a demonstration that modern technology is no guarantee of safer custody.

The report has been anonymised for publication on the PPO website.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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Summary

1. The man was a 21-year-old man from Lancashire. The Magistrates' Court remanded him into custody in March 2005 for breaching his Drug Treatment and Testing Order. Upon arrest he spat at the arresting Police Officer and was further charged with assault.
2. Prison escort contractors took the man to Preston. As he looked physically younger than his 21 years, reception staff ensured that he did not pass through reception until they had confirmed his age. He was identified as having a drug habit and placed on C1 wing, the Drug Dependency Unit, on a nine-day drug dependency detoxification. The man was described by staff and prisoners as a popular individual.
3. C1 wing is below ground level and is a wing that, at the time of investigation, did not have in cell electricity. Prisoners had access to battery-operated radios in their cells. Two days before his death, the man was talking to other inmates about getting off of the wing by carrying out a sit down protest or barricading himself in a cell.
4. On Wednesday 9 March, the man and other prisoners attended a massage and relaxation class in the gymnasium. He appeared to enjoy the class and recorded that it was, "alright okay" on a feedback sheet. He then had exercise on the exercise yard. On leaving the exercise yard, he communicated to a prisoner friend on another wing by shouting up through the prisoner's cell window. He shouted that he would see him later.
5. The man returned to the wing as lunch was being served. He and a fellow prisoner went into cell C21 and shut the door. Staff unlocked the door and persuaded them to leave. They were both placed on a Governor's Report, charged with an offence against Prison Rules. They walked unaided and without the use of restraints to the Care and Separation and Unit. The man was searched and placed in a cell with closed circuit television at around midday.
6. A prison officer physically checked him at 12:35pm by looking into the cell. At that time he was alive and standing at the back of the cell. The officer did not check him again. At 1:35pm, he was found hanging from his bunk bed. He had used his shoelace as a ligature. Despite a prolonged resuscitation attempt by Health Care Staff and Paramedics, the prison doctor pronounced him dead at 2:00pm.

Investigation Methodology

7. The investigation was conducted by two of my investigators. The investigation was opened at Preston on Friday 11 March 2005. The Governor and his staff made available the man's core file and a number of other documents for examination. Notices were issued to staff and prisoners informing them of the investigation.
8. Representatives of the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB) were met by my investigators, informed of the investigation and offered their full co-operation. Contact was made with Lancashire police who carried out the initial police investigation.
9. Documents relating to the man's time in custody were examined and a number of prison staff and prisoners were interviewed. My investigators contacted the Coroner's Officer at Preston to brief him on the nature and scope of my investigation, and to request a copy of the Post Mortem report.
10. Preston Primary Care Trust undertook a clinical audit of the man's care whilst in prison custody. The PCT report is still awaited.
11. One of the investigators and a family liaison officer met the man's father to discuss the investigation and to provide an opportunity for the family to raise questions and concerns.

HMP Preston

12. Preston is a local prison situated near the town centre. It was originally built in 1790, and rebuilt and subsequently enlarged in mid-Victorian times. It is being modernised and developed under a rolling programme of refurbishment. It is currently a local prison serving Crown Court centres at Preston, Burnley, Lancaster and Barrow.
13. HM Chief Inspector of Prisons in her most recent inspection report on Preston in July 2004 made the following observation:

“Preston’s problems are common to many local prisons historic decrepit buildings, under investment, a history of poor industrial relations, and an ever increasing number of prisoners, many of them challenging and needy. It is commendable that Preston has nevertheless made some headway and has a clear vision of what needs to be done to provide positive outcomes for its prisoners. It deserves some breathing space to achieve this; but is unlikely to get it given the current population crisis.”

Description of residential units

- A Wing: Short-term convicted prisoners
B Wing: Mixed convicted and remand prisoners
C Wing: Drug detoxification unit and voluntary testing unit
D Wing: First night centre and prisoner induction
F Wing: Vulnerable prisoners unit
G Wing: Risk-assessed workers and category D prisoners

Drug Dependency Unit (DDU)

14. The Drug Dependency Unit is located in the basement of C wing and has 58 beds. It is freshly painted. The establishment is undergoing a rolling programme of refurbishment but, at the time of this report, the cells in the Drug Dependency Unit had no in cell electricity. Prisoners had access to battery-operated radios in their cells.

Care and Separation Unit (CSU)

15. The Care and Separation Unit is located in the basement of A wing. The CSU comprises 16 cells and two special cells. Eight of the cells have in-cell closed circuit television that is recorded on a 24 hour loop with a television monitor in the wing office. The CSU incorporates an office and an adjudication room. The unit is staffed daily by a Senior Officer and three Officers, Monday to Saturday, and a Senior Officer and two Officers on Sundays. However, during the lunch period and in the mornings and night when the prisoners are locked in their cells, one Officer covers the unit.

16. At the time of the investigation the unit was clean and tidy and the cells in a good state of repair. A number of cells contained bunk beds.

Events prior to the man's death

17. The man was arrested on 28 February for breaching his Drug Treatment and Testing Order. At the time of his arrest, he spat at the police officer who detained him and was further charged with assault. The Magistrates Court remanded him into custody on 1 March. He was conveyed by the escort service to Preston. He arrived at Preston where the reception officer saw him in reception.
18. The officer particularly remembered the man. He described him in interview as looking much younger than his 21 years. The man acknowledged that he looked young, that he had been imprisoned before and that he had no concerns about entering the prison, as he would have acquaintances in Preston. The reception officer completed a cell sharing risk assessment form on him. He was then placed on C1 wing, the Drug Dependency Unit.
19. The following day a registered general nurse and registered mental nurse (RMN) with experience of working in community based Drug Teams, saw the man on the Drug Dependency Unit. He was being seen as part of an initial counselling, assessment, referral, advice and through care (CARAT) interview. The nurse made a comprehensive record of her contact with the man and placed him on a nine-day drug detoxification programme. The only separate recollection she has of him is that he looked very young.
20. A prisoner who shared a cell with the man between Saturday 5 March and Wednesday 9, March was interviewed as part of the investigation. He described the man as being immature and small for his age, describing him as looking 13 or 14 years old. He said the man's interaction with other prisoners was good describing him entering other prisoners' cells when looking for tobacco or cigarette papers.
21. The man mentioned to his former cellmate the name of a particular officer he did not like. The man said the officer was strict when dealing with prisoners. He talked about getting off of the wing. He talked about going down the block (Care and Separation Unit) but also knew that it would not get him permanently off of the wing. The man mentioned refusing to go back to his cell after association, but said he could not do that because he could not get enough people to support him.
22. His cellmate stated that the man saw his probation officer on an afternoon just before he died. When he came back to their cell he said, "It looks like I am looking at four years in prison". He remained quiet for the rest of the day.
23. The man's probation officer visited him on Monday 7 March. He informed her that he was coping with prison and knew a few of his fellow inmates. She saw no indication in his demeanour and speech that he was considering taking his own life. They briefly discussed a custodial

sentence, however as the offence was a minor assault, she informed him that it would be unlikely that he would receive a custodial sentence and if he did it would only be for a period of a few months. At the conclusion of their meeting the man told her that he would see her in court the following week.

24. Another prisoner at Preston and a friend of the man outside prison spoke with him on the Monday before he died. The man was talking about getting off the wing with another prisoner. He told him that he was having problems, that he was suffering from withdrawal and that he desperately wanted to get off the wing. The man spoke at length about barricading himself behind the door or doing something stupid because he really wanted to get off the wing. His friend asked him if he was being bullied and he replied by asking who was going to bully him. The man's friend was of the opinion that the man was very confident despite his size.
25. The man's friend subsequently spoke to the man through his cell window as the man was going to and returning from the exercise yard. He describes them exchanging light hearted abuse with each other and the man said, "I will be over shortly"
26. On Wednesday 9 March between 8:45am and 10:15am, the man attended a massage and relaxation class in the gymnasium. The officer taking the class remembers him taking part in the activity. He did not show any signs of distress.
27. A second prisoner, who was on the Drug Dependency Unit when the man arrived on the unit, was interviewed. He too had known the man outside prison. He described the man's interaction with other prisoners as good. He commented that the man did not like a member of staff on the unit.
28. The second prisoner described going to the relaxation class at the gymnasium with the man on the morning of his death. The second prisoner and his partner at the class felt uncomfortable and left the class. He described the man as having good interaction with the other prisoners and physical education officers.
29. He saw the man later that morning on the exercise yard when they exercised for between 45 minutes and an hour. He described him as, "alright, bubbly not down in the slightest". At lunchtime on the Drug Dependency Unit, he was aware that something had gone on with the man and saw him walk past his cell. The man said "See you later". He was told later that day that the man had died.
30. A third prisoner was at Preston on the Drug Dependency Unit when the man arrived on the unit. In interview he stated "They put stickers on the man's cell door, little stickers with faces on them." These were intended to indicate that the man was a baby, a reference to his young appearance. He stated that the man didn't mind. Later on in the interview, the prisoner claims, a wing officer had placed the stickers on the cell. The prisoner

explained that he partnered the man at a massage and relaxation class in the gymnasium on the morning he died. He described the class as quite good.

31. The physical education officers who ran the massage and relaxation class on the morning of the man's death were interviewed. The man's interaction with the staff and other prisoners was good. At the end of the class, the man was asked how he found it and he replied, "I find it okay. It reminds me of something I did on the out on a project". The first PE officer did not perceive him to be distressed in any way. The man wrote feedback on the class stating "all right okay". The officer did not see anyone who completed the class who was distressed or showing any signs of hopelessness. They were all joining in, they were all communicating with each other and the class atmosphere was good, calm and relaxing.
32. The PE officer and his colleague are experienced officers who said they were shocked when later that day they heard the sad news of the man's death.
33. A fourth prisoner at Preston stated in interview that he knew the man from the Drug Dependency Unit, as he was a friend of his cellmate. He knew him from the exercise yard and association. He describes him as happy and well liked by the other prisoners. He went to the exercise class with the man on the day that he died. The prisoner did not stay at the class, as he felt uncomfortable. He was of the view that the man was alright.
34. The wing officer first met the man on 2 March when he started duty. He stated that the man seemed to know a lot of the lads, and added that he did not show any signs of suicidal tendencies or self harm. The officer commented, "The staff were worried because he was so young looking that he may have been bullied at some time but the banter was good". He explained that the man was laughing and joking and always seemed to be going from one cell to another. In the officer's view the man was like any other inmate.
35. The wing officer remembers the day the man died. The man had been to the gym and out on the exercise yard. He and another prisoner had gone into another prisoner's cell and jammed something at the back of the door. The second wing officer talked them out of the cell, and both prisoners demanded to go to the CSU. The officer saw both prisoners being escorted unrestrained from the wing. He says he cannot recall seeing any stickers on the man's cell door and, if he had he says he would have removed them.
36. A third wing officer who worked on the Drug Dependency Unit, recalls the man as the youngest looking prisoner she had seen at Preston. She recalls that on 9 March before lunch was served, the man had what she describes as a slight tantrum. He said he wanted to move off of the wing. She explained that there was no room to move anybody off at the moment. He then had his lunch.

37. The officer became aware of an incident where the man and another prisoner had gone to a cell not theirs (C21). A fourth wing officer put his foot in the cell door, preventing it closing and talked them out of the cell. She then saw the prisoners being taken unrestrained from the Drug Dependency Unit.
38. A fifth wing officer commented that the man looked young for his age and was popular with the other prisoners. She said at 12:00 midday on 9 March she had been working in the treatment hatch on the Drug Dependency Unit where medication is dispensed to the prisoners. She then began locking prisoners in their cells after they had collected their meals. She saw the man enter cell 21 and knew that was not his cell. She went to the door to ask him what he was doing and he slammed it in her face. She attempted to open the door with her key and the occupants slid a cabinet in front of the door. A prison officer and a duty officer went to her assistance. They opened the door, and talked them out. The man and a fellow prisoner left the cell.
39. The fifth wing officer then completed the forms placing the man and his fellow prisoner on report. She had no more dealings with the two men.
40. The duty officer corroborates the fifth wing officer's account. He said that he saw both the prisoners walked unrestrained off the unit.
41. The unit officer was working in the Care and Separation Unit on Wednesday 9 March when he saw the fourth wing officer and the second wing officer walk onto the unit with the man and his fellow prisoner. He describes the man as slightly agitated but compliant. The man was strip searched to ensure that he did not have anything on him with which he could have harmed himself or others. After the completion of the strip search, he was placed in cell S1 22. He walked into the cell of his own accord.
42. The second prison officer started work on 9 March at midday and went straight to the CSU. The staff went off duty at 12:30pm. The officer was aware that one of the prisoners was on a self-harm watch. He physically checked all the prisoners and then checked the roll for the unit and recorded in his incident statement "seven live bodies." He states that the man was standing in his cell.
43. Cell 22 has an overt closed circuit camera with a recording facility, and a display monitor within the Care and Separation Unit staff office. The camera recorded the man entering the cell at 11:48am. His last movements are recorded at the rear of the bunk bed furthest away from the door at 12:28pm.

Discovery of the man's death

44. At 1:35pm, the third prison officer opened the man's cell in the Care and Separation Unit to collect his dinner tray. On opening the cell door, she saw him in a sitting position at the back of the cell. She asked him if he had a tray and the man did not reply. She then stepped further into the cell and realised there was a shoelace around his neck, tied to the frame of the bunk bed. She stepped back out of the cell into the landing shouting Code 1, indicating to the staff that there was a hanging incident.
45. The fourth and fifth prison officers entered the cell. The fifth prison officer physically lifted the man whilst the fourth officer cut him down with his issued ligature knife. They then carried the man onto the landing outside his cell and placed him in the recovery position. Medical staff arrived and began resuscitation procedures.
46. A prisoner cleaner in the Care and Separation Unit was working at the time the third prison officer discovered the man. He heard her shout Code 1 and as instructed he went back to his cell and was locked in. He did not know the man or have any knowledge of him.
47. A prisoner in the Care and Separation Unit, heard the third prison officer shout Code 1 and call for fish hook which is a reference to an anti ligature knife.
48. The duty governor on call on the day of the man's death was informed by telephone that two prisoners had been removed from the Drug Dependency Unit to the Care and Separation Unit. As she was in a meeting, she decided to sign the relevant paperwork at the conclusion of her meeting. At 1:30pm, as a result of a Code 1 message over her radio, she attended the CSU. There were medical staff in attendance dealing with the incident. She signed the paperwork for the man and his fellow prisoner, and started making arrangements to have prison staff escort the man out of the prison. Attempts were made to contact the man's next of kin.
49. The head of healthcare, said she was aware of a Code 1 incident being broadcast over the prison internal communication radio system and the location. She ran to the incident and requested en route that a member of staff bring the defibrillator. Upon arrival, she saw that a number of staff had already responded and mouth to mouth resuscitation and chest compressions were being given to the man by her staff. The emergency equipment bag was already there. Two other staff were putting together the Ambu bag equipment. The head of healthcare requested, further oxygen be brought to the incident as it was possible that the resuscitation could be prolonged.
50. The head of healthcare then went to help her staff in resuscitating the man. The nurse performing mouth to mouth was having difficulty obtaining a seal around the man's mouth with the resuscitation mask. The head of

healthcare then took over giving direct skin to skin mouth to mouth resuscitation. They then used an oxygen Ambu bag on the man. The ambulance team arrived whilst resuscitation was being given. The defibrillator was attached but gave a flat reading. The prison doctor arrived. After 20 minutes of trying to resuscitate the man, the prison doctor, the paramedics and the head of healthcare decided to call an end to the resuscitation attempt.

51. The prison doctor pronounced the man dead at 2.00pm.

Next of Kin

52. As soon as the man had died the chaplain tried to trace the man's next of kin. The man had only given part addresses or part details of his next of kin, which made them difficult to contact. His father was eventually traced with the help of the South Wales Police. One of my family liaison officers continues to have contact with the man's father and sister.

Observations and Conclusion

53. The man led a chaotic life. He had an expensive drug habit that he funded through crime. Although aged 21 he looked much younger than his years. He arrived at Preston on 1 March and was subsequently placed on a nine-day drug detoxification programme within the Drug Dependency Unit. Staff and prisoners describe him as a popular person who interacted well with other prisoners, some of whom he knew from outside prison. Whilst on the Drug Dependency Unit he shared a cell with another prisoner, and participated in the gymnasium, library and exercise. There is some suggestion made by prisoners that he did not interact well with one particular officer. On the day of his death, he had attended a massage and relaxation class and showed no outward signs of isolation or despair. He exercised with other prisoners, and shouted to a fellow prisoner that he would see him later. It is known he discussed getting off of the wing with other prisoners, talking about a sit down protest and a barricade to effect his move.
54. The man had nearly completed his drug detoxification programme and would have been relocated to a wing when space became available.
55. On Wednesday 9 March, the man and his fellow prisoner, who was on a self-harm watch, barricaded themselves in a cell. They were taken to the CSU. Unfortunately, they were taken at a time of day when the unit was going onto patrol state. One member of staff was relieving the senior officer and three staff on duty in order that they could have their lunch.
56. At the time the man and his fellow prisoner were taken to the unit there were five other prisoners located there. The man was placed in a single cell and was alone for the first time since he had arrived at Preston. The cell had an active closed circuit television camera, which recorded his last movements alive. The officer on duty checked him at 12:35pm and he says that the man was alive and standing at the back of his cell. The Care and Separation Unit hourly prisoner check sheet, has been signed at 12:00 midday but there was not a signed entry for 1:00pm. The officer on duty is aware that he did not sign the check sheet at 1:00pm.
57. The man was found hanging in his cell at 1:35pm when the senior officer and his three Officers returned from lunch.
58. An attempt was made to revive the man by qualified nurses and staff working on him for over 25 minutes, prior to a doctor pronouncing he had died.
59. There was no indication from those staff and prisoners interviewed that the man had any inclination to take his own life.
60. The allegation made against a particular prison officer by some of the prisoners has been brought to the attention of the Governor.

61. The report has been completed without the benefit of the clinical review. Should the clinical review raise separate issues relating to the man's healthcare needs, a supplementary report will be submitted.

Recommendations

1. I recommend that bunk beds are removed from the Care and Separation Unit.
2. I recommend that the governor reviews the use and recording of CCTV in light of the sad circumstances of the man's death.
3. I recommend that the governor reminds senior colleagues that staffing levels in the Care and Separation Unit during patrol state should be routinely risk assessed in light of specific operational demands.
4. I recommend that the governor reviews staffing levels in the Care and Separation Unit during patrol state.
5. I recommend the inclusion of smaller resuscitation face masks in first aid kits.

Good Practice

The response by the staff on finding the man and those staff involved in the resuscitation attempt was excellent.

I also commend the level of detailed note taking in the RMN's initial assessment of the man.