Investigation into the circumstances surrounding the death of a prisoner, at HMP Full Sutton, on 13 March 2005

Prisons and Probation Ombudsman for England and Wales

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This is the report of an investigation into the death of a man on 13 March 2005. The man, who was aged 56, was a category A prisoner at HMP Full Sutton. He was found unconscious his cell, having taken an overdose of medication that he had not been prescribed, and died before the ambulance could leave the prison. Every indication is that the man intended to take his own life.

I offer my sincere condolences to the man's family for their loss.

My office investigates the death of all prisoners in custody. In this case, two investigators from my office carried out the investigation. I am grateful for the assistance they received from the staff and management of HMP Full Sutton. I am conscious that, when a death occurs in prison, it can have just as profound effect on staff as on prisoners, or on the family and friends of those who have died. This is perhaps especially true in a long-term prison, where staff get to know those in their charge over many months and years.

I also wish to acknowledge the help of Humberside Police based at Beverley Police Station who carried out an enquiry into the man's death and shared the information they gathered. My thanks also go East Yorkshire Primary Care Trust who conducted the clinical review.

The man was a life sentence prisoner who had been in custody since 1994. Although most self-inflicted deaths occur in the first few days or weeks after someone comes into prison, the death of the man serves as a reminder of the vulnerability of long-term prisoners, often after having served many years continuously in custody

This investigation has not been able to answer every question about the circumstances leading to the man's death. I do not know how the man obtained the medication that killed him. Nor is it clear if he was conscious at any point on Saturday 12 March. If he was comatose throughout the day, then this would call into question the integrity of the checks conducted on the fabric of his cell. That may be an irrelevant matter in regard to the tragedy of the man's death. But in the context of a high security prison, it is of wider public concern.

Stephen Shaw CBE
Prisons and Probation Ombudsman **March 2006**

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Summary

This is the report of an investigation into the death of a man. The man was aged 56 when he died at 8.30am on 13 March 2005. He was a prisoner at HMP Full Sutton and had been found unconscious his cell earlier that morning.

The man had been in custody since 1994 and was serving a life sentence for murder. He had been at Full Sutton since 7 June 2002. He was not considered to be at risk of suicide when he died, but had previously self-harmed and been subject to suicide and self-harm prevention procedures at several points earlier in his sentence.

As with all long-term prisoners, the man was required to reduce his risk of offending by completing courses and programmes. Unfortunately, due to his learning difficulties, he was unable to complete the courses offered by the Prison Service. Amongst other things, the man was dyslexic which prevented him from taking part in accredited behavioural programmes, although he was willing to try. This was a source of frustration for the man as he wanted to progress through his life sentence, but was unable to do so. It was this frustration, amongst other factors, that may have led the man to plan his own death.

On Friday 11 March 2005, the man told staff that he had a headache and was excused from work. Earlier that week, the man had told another prisoner that he was going to have a “drink” on the Friday night, as it was his birthday (although the man’s birthday was actually in October). On the Saturday morning, when the man did not leave his cell for breakfast, as was his usual routine, the prisoner assumed he was hung over and left him to sleep. He made the same assumption a number of times that day.

Members of prison staff do not specifically remember seeing the man on the Saturday. However, they told my investigators that, if they had not seen him, that would have been unusual and they would have realised there was something wrong. Additionally, prison staff signed the necessary papers to confirm that the fabric and condition of the man’s cell was checked. To complete this check, the prisoner must leave his cell. The prisoner, who the man confided in, claims that this did not happen.

When the man did not wake again on the Sunday morning, the prisoner who the man confided in alerted staff. The man was found unconscious, medical aid was given and an ambulance was called. Unfortunately, the man died whilst in the ambulance before it even left the prison. The cause of death was a massive overdose of the drug, Tramadol.

Following the post-mortem, the pathologist estimated that the man had taken over 50 Tramadol tablets. If he had taken them on the Friday night, it was unlikely that the man would have been able to walk on the Saturday.

The man left two apparent suicide notes in his cell – one addressed to his daughter.

This report looks at the man's time in prison custody and whether the care and support offered to him was appropriate and reasonable. I make a number of recommendations and endorse those made in the clinical review, along with the highlighted good practice.

Investigation Outline

The investigation into the man's death was conducted by two investigators from my office. They visited Full Sutton and were shown the areas where the man would have been, including the workshop that the man attended and the wing on which he was located.

They issued a notice to staff and prisoners inviting anyone with information relating to the man's death to make themselves known to the investigation team.

The investigators also spoke to the Chair of the Independent Monitoring Board (IMB), the Prison Officers' Association (POA), one of the prison chaplains, and various other members of staff, including the Safer Custody Manager. The investigators formally interviewed prison staff and informally spoke to prisoners who were involved in the events surrounding the man's death.

The prison gave my investigators full access to all the documentation surrounding the man's time in prison. The police also provided copies of the documents and statements in their possession.

Soon after the man's death, my investigators visited his wife and daughter to discuss their concerns and questions they wanted answered.

Finally, my investigators commissioned East Yorkshire Primary Care Trust to conduct a clinical audit of the man's care while in prison.

Background

The man

The man was born on 2 October 1949 and was 55 years old when he died and was the third in a family of nine children.

The man was a category A prisoner, which means he was held under the highest security conditions. On 1 March 1995, he had been sentenced to life imprisonment, with a tariff of 14 years, for the murder of his business associate. There were other related offences. At the time of the murder, the man was a habitual drug user.

As a prisoner, the man was described as a quiet and polite person, who kept himself to himself. Both staff and fellow prisoners told my investigators that he only spoke to staff when he was spoken to. The man had been a heroin addict, but had been "drug free" for about seven years. He had learning difficulties and was dyslexic. This prevented him undertaking accredited behavioural programmes whilst in prison, but he did complete a number of unaccredited programmes.

HMP Full Sutton

Full Sutton is a high security prison holding some of the most difficult and dangerous offenders in the country. It was opened in 1987 and is a modern, purpose built maximum security prison for male category A and B prisoners.

The four original residential units are of a square design: A wing holds main wing prisoners; B, C and D Wings hold vulnerable prisoners. E and F wings, which were added later, are of improved design and both hold main wing prisoners. Half of F wing houses the segregation unit. G wing is used for induction and also holds some vulnerable prisoners.

In January 2003, Her Majesty's Chief Inspector of Prisons conducted a full inspection. During her inspection, the Chief Inspector found Full Sutton to be a much safer place than it had been, both for prisoners and staff. It presented an ordered, controlled environment, and there was a low level of recorded incidents.

The Chair of the IMB told my investigators that Full Sutton was a safe and caring environment, with good staff and prisoner relationships.

My investigators reviewed Safer Custody practice at Full Sutton and found that the Prison Service requirements were met and often exceeded. Staff were aware of the F2052SH system (the documentation and procedures to assist those at risk of suicide or self-harm), and of the need to act quickly should they suspect any prisoner might be thinking of self harm.

Information is displayed widely in all areas of the prison and includes details of how staff can help prisoners. The Listeners scheme is also explained.

(This is an arrangement where prisoners who have problems, but feel unable to talk to staff, can talk to other prisoners who have been specially chosen and trained by the Samaritans.) There is also comprehensive written information on how to contact the Samaritans. The telephone booths on the wings have the Samaritan message and free phone number displayed prominently.

The prison's Safer Custody Group meets every two months. It is chaired by the head of residence (a governor grade) and attended by staff and Listeners. Suicide Awareness is a standing agenda item, as are Listeners' reports and examination of F2052SH (self harm) statistics. The meeting is well attended.

Chronology of Events

1994 – 2004

Following his reception into HMP Exeter on 1 January 1994, the man was described as being “disturbed and sad” while on remand. He had been using heroin and methadone and said that he was suicidal. He felt that he had lost his wife and daughter. He described himself as a loner.

In July 1994, the man was found unconscious in his cell and was admitted to a local hospital. There he was found to have taken an opiate overdose which was complicated by pneumonia.

During August 1994, the man said that he would kill himself at some stage, and that he was not going to do 20 years behind bars. In September 1994, he had hoarded his valium and taken a lot at once. As it was not helping him, it was discontinued. He was described as “profoundly depressed, suicidal and hopeless”. The man was still using illicit drugs.

During February 1995, the man took another overdose.

On 1 March 1995, the man was sentenced to life imprisonment with a minimum time to serve (‘tariff’) of 14 years. He was returned to HMP Bristol that day and, on 4 May 1995, he was transferred to HMP Full Sutton.

At the end of March 1995, the man had been found in his cell drowsy, unsteady on his feet and with slurred speech. He was admitted to hospital again on suspicion of another overdose. He said that he had bought tablets in return for phone cards over a period of months until he had a hoard of 200, although he said he had given 50 of them to another prisoner. A forensic psychiatrist said that the man was clinically depressed and prescribed antidepressant medication. Within a few days, he had ceased complying with this medication.

During February 1996, the man requested to go on a detoxification programme to withdraw from heroin which he completed successfully. On 29 April 1996, he moved to HMP Long Lartin.

In August 1996, the man was admitted to hospital following an overdose of 50 amitryptilline tablets which he said he got from another prisoner. On his return to the prison, he said that he saw no point in carrying on his life as he was serving a life sentence.

Early in October 1996, the man was found collapsed in his cell and was thought to have taken a further overdose. Opiates and cannabinoids were found in his urine on admission to the local hospital. His recovery was complicated by pneumonia. Following his discharge from hospital on 14 October, the man began refusing food although he was still drinking. Healthcare staff were concerned about his ongoing and longstanding risk of suicide. However, the man refused to talk with the visiting psychiatrist.

On 21 October 1996, the man was transferred to HMP Frankland. Although his food refusal continued, towards the end of the month he started drinking milk and tea. On 25 November, the man started eating again.

During March 1998, the man completed a life skills course. In June 1998, he was found unconscious by staff and taken to hospital where he was found to have swallowed a condom containing drugs. After spending six days in an intensive care ward, he was moved to a general ward and then back to prison. Here, he was located in the prison healthcare department and treated as an in-patient for deep vein thrombosis which was thought to be a complication arising out of the drug overdose.

In July 1998, the man was diagnosed with deep vein thrombosis but refused treatment. He said that he wished to die naturally. Although he said that he was happy to discuss pleasant events from his past, he would not discuss the future as he insisted that he would not be here. He became low in mood at this point and said he felt guilty about the trouble he had caused his family.

When the man was transferred HMP Wakefield on 28 September 1998, he was identified as needing to complete offending behaviour programmes to help him deal with his use of violence and drug abuse. This was also felt necessary to help him to cope with his thoughts of self-harm. The man was assessed, and the education department noted that the man struggled with his reading and writing. He was very likely to have been dyslexic. At this time, the man told staff that he intended to complete his sentence.

For almost four years after this, the man appeared to be stable with no notable incidents occurring. The man was transferred back to Full Sutton on 7 June 2002, and was reassessed for programmes such as Enhanced Thinking and Focus (drug awareness) but was considered unsuitable due to his level of education. However, it was noted that, should an adapted version of these programmes become available, he should be reassessed. The man applied for the enhanced thinking course again in June 2003, but it decided that it would not be of benefit to him for the same reasons.

In September 2003, the man took a further overdose with tablets he said were purchased from another prisoner. He described this overdose as a cry for help. From this time, he stopped visits from his wife.

In August 2004, he visited the prison walk in centre and said that he had never taken his antidepressants but stored them up for use as an overdose. The man was assessed by a forensic psychiatrist who concluded that he had poor coping skills, particularly at times of stress, which made him prone to self harm. In November 2004, the man stopped all contact with his wife and probation officer.

Throughout his prison sentence, when the man attempted to self-harm or required additional support, he was managed using the F2052SH system. His last F2052SH was closed in January 2004, as he appeared to be stable and coping independently.

2005

The man's security categorisation had been reviewed every year but he had remained a category A prisoner. The last review took place in January 2005 at which it was decided he should remain within category A as it was believed his offending risk factors had not been reduced sufficiently. The review team noted that the man's custodial behaviour posed staff no threats or problems, and that he had received no adjudications since 1998.

They also noted that, although the man showed a willingness to take part in Offending Behaviour Programmes (which would attempt to reduce his risk of re-offending), none were available to him at that time due to his learning difficulties. Nor had they been for the previous ten years of his sentence. The man became very frustrated about this situation, as he was more than willing to participate in programmes. Yet, because they were not available, he was unable to progress through his sentence. The review team stated that until the man completed these programmes, he should remain a category A prisoner and stay in high security conditions.

On 18 January, the Lifer Manager wrote a progress report about the man. The report describes a "catch 22" situation. The man was willing to complete Offending Behaviour Programmes, but his learning difficulties precluded him from starting them.

On 28 January, the man was told that his wife and daughter had received prison sentences. His personal officer said that the man had accepted this news calmly. In February, the man was contacted by Psychology with a view to their carrying out one to one sessions with him sometime in the near future. The man also spoke to a landing officer at length about his lack of progress, and the frustration that he was feeling.

A prisoner located on the same wing as the man, told my investigators that on about 6 March the man told him that it would be his birthday soon. The man's date of birth was actually 2 October, seven months away.

On 9 March, the man was reviewed by the Parole Board for the first time. The Board felt the man had not made adequate progress in addressing his offending behaviour, echoing the view of the category A review in January 2005. He would have been due a further review in December 2007.

Another prisoner told my investigators that, on 11 March, the man told him that he would never be released from prison. He said that this was a statement that the man made regularly, and did not seem out of place. It certainly did not make him consider that the man might harm himself.

Friday 11 March

On the morning of 11 March, the man did not attend work. This was unusual, as he was normally the first in the queue to leave the wing. He told wing staff that he had a migraine and would need the day off work. The man also made sure the staff explained the situation to the workshop instructor, so that he would not lose any pay. The man had never abused the sick system, so the instructor agreed to pay the man for the day. Staff said they had no concerns about this. Although it was unusual for the man to miss work, he gave a perfectly plausible reason.

A friend, who was also a prisoner and was probably the closest to the man, spent some time with him in the afternoon and for the first time the man, showed him his family album. During this conversation, the man said that it was his birthday and that he intended to have a drink that evening. He went on to say that, if his friend found him asleep the next morning, then he should not attempt to wake him. His friend knew that the man had the ability to brew alcohol in his cell. His friend was not suspicious about anything the man had said to him.

That evening, the man was locked in his cell and nothing unusual was reported throughout the night.

Saturday 12 March

At about 8:00am on 12 March, prisoners on the wing were unlocked for breakfast. Staff are only required to ensure prisoners are in their cells, but not to wake them or get them to acknowledge them. Staff saw that the man was in his cell lying in bed asleep and snoring. His friend collected a meal, and on the way back to his cell, called in to see the man. As he appeared to be asleep, making a noise as if he was snoring, he did not disturb him.

His friend went back to the man's cell at 10:00am and again at midday. Both times, the man appeared to be lying on his back asleep. Remembering that the man had said that he was going to have a drink the previous evening, his friend was not concerned and left him to sleep.

At 2:00pm and again at 4:50pm, before the cells were locked up for the night, his friend checked the man and again he appeared to be lying on his back asleep, making a snoring-like noise. His friend again did not disturb him, but filled the man's flask with hot water so he could have a hot drink if he wanted one. Whilst his friend thought it unusual for the man to still be asleep, he was not suspicious, simply assuming that the man was hung-over and was "sleeping it off".

His friend told my investigators that once a day the officers complete Accommodation Fabric Checks (AFCs). To do this, the prisoner is asked to leave the cell, and the officer checks the security of the cell. When AFCs are completed, the officer who carried them out signs a document to that effect. The wing manager also signs to say that they have supervised the staff doing

the AFCs. his friend told my investigators that this does not happen every day, but staff often signs to say they have done them anyway. His friend also told my investigators that the AFCs were not completed on the 12 March.

The AFC sheet for 12 March was completed by staff and the supervising wing manager. This states that an officer completed AFC checks on the man's cell at 10:30am, and that the wing manager, supervised them being done and that they were completed to the required standard.

During the day, none of the staff or prisoners my investigators spoke to, with the exception of his friend, remembers seeing the man, either in or out of his cell. However, staff told my investigators that if they had not seen the man on the landing or collecting a meal, then they would have thought it unusual and checked that he was alright. They concluded, therefore, that they must have seen him that day.

At about 5:00pm, the man was locked in his cell, and again there were nothing unusual reported throughout the night.

Sunday 13 March

Overnight, the man was observed by the night-patrol, apparently sleeping. At about 8.32am, an officer unlocked the man's cell for breakfast. As the man appeared to be asleep, the officer did not attempt to rouse him but simply unlocked the door and checked that he was in his cell. He said this was not unusual, as at a weekend prisoners often stayed in bed.

His friend collected his meal, and again called in to see the man. He still appeared to be asleep, making a noise like he was snoring. His friend was concerned by this as the man had been asleep for such a long time. At 8:50am, he told another officer that he had concerns about the man.

At 8:52am, the officer attended the man's cell but could not awaken him. He was unresponsive, but breathing and appeared asleep. The officer who attended the cell called the officer who unlocked the cell and the wing SO who also tried to rouse the man. They could not, so the officer who attended the cell left the cell and telephoned healthcare for assistance.

At 9am, a nurse and healthcare assistant arrived in the man's cell. They removed his bedding and found that he was fully dressed. The nurse said that there was a trace of vomit on the man's cheek. His breathing was described as spontaneous, but with a slow respiratory rate. His blood pressure and pulse were undetectable, although ECG showed a heart rhythm to be present. The man was administered oxygen and his pulse and blood pressure monitored. The nurse checked the rest of the man's body for injuries, and continued to monitor him.

The emergency services were called at 9:11am. The doctor arrived at 9:15am. After a brief examination, the doctor was satisfied that the situation

was under control, the man was stable and an ambulance was on the way. The doctor could add nothing further so left the wing.

At 9:40am, an ambulance arrived at the prison and, minutes later, the ambulance crew took control. At 9:44am, the man left the wing to be placed in the ambulance. Once in the ambulance, the escort SO was handcuffed to the man. As the ambulance travelled to the gate, staff were already in position to open the compound gates to prevent delays.

At 10:00am, the man vomited and his condition was clearly deteriorating so the ambulance stopped in the gate sterile area whilst the paramedics treated him. At this time, the handcuff was removed. Healthcare staff were informed and the doctor was asked to attend. Respiratory and cardiac arrest occurred in the ambulance. Unfortunately, resuscitation attempts were unsuccessful.

At 10:22am, the man was pronounced dead by the doctor. At 10:26am, the prison chaplain saw the man’s body in the ambulance and gave the last rites.

Events after the man’s death

The cell door was secured with a security lock, and the cell was treated as a potential crime scene until the police arrived. Staff involved submitted comprehensive statements to the Governor, providing a detailed account of the discovery and management of the incident. All necessary paperwork was completed, both during and after the death, to record events in accordance with the local contingency plans for a death in custody.

Two suicide notes were found in the man’s cell. The first one was written to his daughter, contained his wedding ring and indicated that he wanted to take his own life. The other note was written to the prison Governor. The man said that he had no complaints about the prison but that he wanted to end it all and have his property sent to his daughter.

As the man’s wife and his daughter are both serving prisoners in other establishments, the duty governor contacted the duty governors at both prisons and arranged for both of them to be told the sad news.

At 10:45am, the deputy governor chaired a ‘hot debrief’ for staff. It appears that all staff involved that morning attended and discussed what had occurred. The Staff Care team were made available to staff, and the Listeners were made available to any prisoner affected by the man’s death.

On 16 March, the Governor sent two of his managers, in the company of the Chaplain, to visit the man’s wife and daughter and offer them support and information. Following this meeting, the man’s daughter was given her father’s belongings.

On 5 May, my investigators also visited the man’s daughter and wife. A number of issues were raised which are covered by this report. The man’s

wife said she knew that the man would plan to take his life in a manner that was difficult for those around him to predict.

The post mortem concluded that the man died of an overdose of Tramadol, a drug that was not prescribed to the man. There were six prisoners in Full Sutton who were prescribed Tramadol. When my investigators asked them, they all denied giving or selling any of their medication to anybody else as they said they needed it themselves. Tramadol is issued to prisoners in advance, in a pack that lasts for a prescribed period. It is not a drug over which staff exercise control as to when a prisoner takes his medication.

Tramadol is an opiate based medication, prescribed for moderate to severe pain relief, with a recommended daily limit of 400mg (four tablets). The effects of an overdose are that the central nervous system is depressed which leads to a deep coma, cyanosis and a marked reduction of the respiratory rate before respiratory arrest occurs.

A Consultant Chemical Pathologist was consulted by the Coroner. He could not be conclusive, but estimated that the man had taken over fifty 100 mg Tramadol tablets. He went on to say that, if the man had taken the overdose on the Friday, then it would be unlikely that he would be able to walk around his cell on the Saturday as he would have been extremely sedated. He also said that, if the man had taken the overdose on Friday but had been found on the Saturday and given appropriate medical intervention, then on the balance of probability his life could have been saved.

Clinical review

East Yorkshire Primary Care Trust carried out the clinical review. Comparing health services the man received in the prison with those he could have expected to receive in the community, they conclude:

- The standard of record keeping is good with sufficiently detailed, contemporaneous notes enabling a clear understanding of the health assessments made and the care provided. There are occasional problems with legibility and with relating the various aspects of the record to each other e.g. prescription charts and hospital letters.

- The man had a number of underlying factors associated with a higher risk of suicide:

  - he was male and isolated from family support;
  - he was a substance misuser and had abused alcohol in the past;
  - he had a turbulent and possibly violent family background and personal history;
  - he had a low level of educational attainment;
  - he had stated his intention to commit suicide and had attempted to do so.

As in primary care in the community, the man had been referred urgently to a psychiatrist when a high risk of suicide was present. However, the receiving clinician was frequently a forensic psychiatrist, rather than a psychiatrist as would be usual in mainstream primary care. Furthermore, it is unclear to what extent many of the mental health professionals felt a responsibility to provide ongoing care, as opposed to further assessment and treatment recommendations. It would be usual for a mental health trust to provide ongoing care when such a high risk of suicide was identified.

A number of references are made in the clinical record to the man's unwillingness to comply with antidepressant medication for any length of time or to accept psychological intervention. This is a common problem in managing depression in primary care, particularly amongst men. However, the man did accept services which did not have a "mental health illness label" such as detoxification, smoking cessation and life skills.

Differing views are recorded as to whether the man was in fact clinically depressed or suffering understandable distress as the result of his predicament – which might be expected to occur in many prisoners with long sentences, in a fairly uncongenial environment.

Findings and Conclusions

There is no doubt that the man was troubled by the fact that he was not able to progress through his life sentence to a point where he could expect to be released back into society. This was due to the man's inability to participate in the offending behaviour courses currently available in the Prison Service. He was prepared to attend, but was not intellectually able to complete the courses. There are no easy answers to this conundrum, although I am aware that adapted versions of some offending behaviour courses are available for prisoners who do not have the intellectual ability to complete the main programmes.

The man made an elaborate and determined plan to kill himself. He acquired a relatively large quantity (50+) of Tramadol tablets. I have not been able to establish whether these came from another prisoner or whether the man had another source. This investigation calls into question the policy of allowing opiate medication to be held in prisoner's possession, rather than being issued and taken in the presence of a member of staff.

It is clear that the man used the excuse of having a drink of prison brewed 'hooch' to distract his friend from alerting staff to his apparent sleepy condition on the Saturday morning. The man said that the reason for the drink was his birthday, when in fact his birthday was in October.

There are conflicting versions of events on Saturday 12 March. Staff say they do not remember seeing the man that day, but felt sure that if they did not see him they would have remembered that fact. They conclude, therefore, that they must have seen him on out of his cell. I note that staff have signed to confirm they conducted the cell fabric checks, which would have required the man to have left his cell. His friend said that the man did not wake all day, and therefore did not leave his cell on the Saturday. He also said that cell fabric checks were not conducted that Saturday, but were signed for by staff to satisfy auditors.

I have not been able to establish with certainty the correct version of events. However, if the man took the overdose on Friday, as his suicide notes suggest, then the evidence of the pathologist suggests that his friend's version is correct and the man did not wake all day. However, I cannot conclude authoritatively whether the man took the overdose on Friday or Saturday. It is clear that the man planned his actions carefully and minimised the likelihood of being found alive.

Emergency Medical Assistance

Once alerted on the Sunday morning by his friend, staff attended to the man very quickly. Medical professionals administered emergency aid as soon as the man's condition became apparent. The prompt arrival at the cell of the Ambulance Service is also impressive.

Urgent efforts were made to revive the man. However, he died in the ambulance before it could leave the prison gatelodge.

Contingency Arrangements

Prison Service Order (PSO) 2710 gives instructions on the actions to be taken following a death in custody, including the support arrangements for staff and prisoners. It says that priority must be given to communicating the facts about the death to prisoners and staff. Any prisoner who may have been particularly affected by the death should be offered support. There should be an immediate post-incident debrief (a 'hot debrief') of staff involved before they go off duty, and a duty care team member identified.

Staff followed procedures that morning in line with local contingency plans and PSO 2710. Various individuals were informed of events as required and the necessary reports were submitted. The care and support of staff and prisoners was dealt with appropriately.

Medical Care

The clinical review concludes that the man's medical needs were managed acceptably, and there was a thorough and regular assessment of the risk of suicide by healthcare professionals. I endorse the recommendations made in the clinical review and repeat them on page 19 below.

Suicide Awareness

Full Sutton prison's local Suicide Prevention Strategy is a comprehensive policy document which is consistent with national policy.

The man was managed well whilst he was at Full Sutton prison. He was identified as being vulnerable earlier in his time there and was properly supported. The last occasion where the man was supported on a F2052SH was in September 2003 following an overdose. This F2052SH was closed in January 2004, as the man was felt able to cope on his own. Even when he was told in January 2005 that his wife and daughter had been imprisoned, he appeared to react calmly.

Staff and prisoners had no suspicions that the man might take his own life. The prisoner on the same wing said it was not unusual for the man to remain in his cell as he was a private man. Another prisoner said the man did not offer to speak to staff, he would collect his dinner and return to his cell. However, the man's wife told the investigators that she was not surprised and knew that the man would plan to take his life in a manner that was difficult for those around him to predict.

Recommendations

The Governor should ensure that:

1. All prisoners are reminded that, if they discover a prisoner who they suspect is unwell or confined to his cell, they should alert staff.

2. All staff are reminded of the requirement to interact with prisoners, particularly those who remain in their cells.

3. All staff are reminded of the importance of carrying out full cell fabric checks.

4. The cell fabric checks procedure should be reviewed urgently to ensure a robust and reliable system.

5. The policy of issuing opiate medication to prisoners to keep in their possession should be reviewed and monitored.

6. Alternative methods of addressing offending behaviour are considered for prisoners who do not have the intellectual ability to complete the existing accredited courses, and that these are taken into consideration in reviews of a prisoner's security category.

Recommendations from the Clinical Review

Areas where development may be appropriate are:

1. **Electronic healthcare record**: the provision of a clinical software system would greatly improve the ease of use and retrieval of information from the record. This could be taken forward locally. As there are issues of transfer of information associated with fairly regular moves of prisoners between prisons and the place of prison healthcare records in the National Programme for Information Technology (NPfIT), it may be more appropriate to take this forward at an NPfIT cluster or national level

2. **Significant event audit and review process**: the prison healthcare team should consider developing an internal process for reviewing such incidents. This could be guided by the relevant part of the Quality and Outcomes framework (Education Indicators 2 and 7) which is part of the new general practitioner contract. This could be taken forward locally within the prison supported by members of the PCT locality and clinical governance teams.

3. **"Talking treatments"**: it may be appropriate to expand the provision of non-pharmacological interventions for depression and disabling distress taking particular account of the needs of a male population with a potentially low level of verbal skills that are unlikely to respond to a diagnosis of mental illness. This could be taken forward locally by

interested staff within the prison and as part of the PCT primary care mental health workstream of the LDP.

4. **Preventive healthcare**: the screening and prevention aspects of healthcare could be reviewed within the prison and in partnership with staff from local general practices and the PCT to promote good uptake and effectiveness of such a service. This could be taken forward locally. Learning from good practice could occur at prison health development events as well as local PCT events and form partnership working with clinical and managerial colleagues within the PCT community.

5. **Referral audit**: the review and development of alternative models of management of demand for primary care services is an ongoing issue in the PCT driven both by modernisation and the provision of a wide range of services close to the patient's home and by resource constraints. It is recognised that this is already an active agenda within the prison as referral is even more resource intensive in that setting. However the personal professional aspects of referral audit could also be taken forward as part of the PCT referral management scheme.

6. **Medicines management**: the management of opiate prescribing and dispensing could be reviewed. Currently there is much sharing of good practice at both national and local level. This work could be taken forward as part of the Strategic Health Authority Controlled Drugs action plan which is one outcome of the Shipman enquiry.

Good Practice

A number of areas of good practice were identified in particular:

- the well organised and informative health record

- the regular and thorough assessment of risk of suicide

- the provision of a range of lifestyle advice with success in detoxification and smoking cessation

- the management of a prolonged period of food refusal in a sensitive and patient-centred manner.