

**Circumstances surrounding the death of
a man
at HM Prison Wakefield in March 2005**

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

March 2006

This is the report of an investigation into the circumstances surrounding the death of a man at HM Prison Wakefield on 20 March 2005. The man, who was a high security (category A) life sentence prisoner aged 37, was found dead in his cell at 7.05pm on that day.

A bed sheet had been fashioned into a noose and was wrapped tightly around the man's neck. He had also injured himself by cutting his right arm.

The man had been subject to a special suicide and self-harm watch, a formal process by which staff open and maintain documentation to ensure detailed attention and a record of events in the lives of those prisoners at risk of suicide and self harm. The process is known as 'F2052SH, the 'F2052 being the form number and 'SH' an abbreviation of Self Harm. He left no note or letter.

I offer my sincere condolences to the man's relations. They have suffered the loss of a much loved member of their family. I know that staff at Wakefield share something of that sense of loss. The man was well known to them and many members of staff had supported him sympathetically during the years he spent at Wakefield. I am aware that members of prison staff attended his funeral.

A post mortem examination was performed at a hospital, on 21 March 2005, by a Consultant Home Office Pathologist. The Consultant Home Office Pathologist concluded that death was caused by hanging. He noted the injuries to the man's right arm but observed that they were superficial and did not contribute to his death. A toxicology examination was conducted, all results were negative.

One of my investigators carried out this investigation on my behalf, assisted by another of my investigators. As part of their investigation, they commissioned an independent review into the clinical management of the man. I am grateful to colleagues who carried out the review on behalf of the Primary Care Trust.

My thanks go also the Governor and all Wakefield staff, liaising with my investigators enabled the investigation to be thorough and to be completed in a timely fashion.

I make seven recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman

March 2006

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1. Summary

The man was born in Scotland and brought up there. He had four siblings, one full brother, two half sisters and one half brother. From the age of three, together with his brother, the man lived in a children's home and was in the care of the local authority. At the time of his death, the man had lost touch with all his family except for occasional telephone contact with his brother.

The man had served several prison sentences, and on one occasion had been subject to an order under the 1983 Mental Health Act. The life sentence he was serving at the time of his death was imposed in 1994. It had resulted from an incident at Broadmoor when the man seriously assaulted a fellow patient.

The man did not find life easy in prison. He was troubled, distracted and sometimes disruptive. He injured himself many times over the years. He had a well-known dislike of sex offenders and of those who committed offences against children. This dislike escalated sometimes to threats and outbursts. The Parole Board, although noting progress from time to time, considered he posed a significant risk to the public.

Prison staff showed care and consideration for the man. Although he did better as a patient in the health care centre than he did as a prisoner on ordinary location, he was not always an easy patient, and he sometimes disrupted life for others. Plans to help him survive in the general prison community usually worked out well initially, only subsequently to fail whereupon the man would spend another period in health care in order to stabilise his life. The cycle then repeated, and he moved many times between ordinary location and health care centres in prisons.

On the evening he died, the man had cut his arm. The injuries were not serious, and the health care officer who treated him, and who knew him well, bandaged the cuts and talked to him. He said that he was feeling better and would not hurt himself again. Before leaving the man's cell at about 6.55pm, the health care officer opened a file known in prison as F2050SH. The 'SH' part of that file means 'Self Harm'. The file is initiated and a written narrative maintained within it in order to ensure that special precautions, including regular observation and interaction between prisoner and staff are taken in respect of those who are at risk of suicide or self harm. Ten minutes later, the officer on duty in the prison wing looked in on the man to find him hanging.

Wing staff tried to revive him. They worked valiantly and without regard for themselves, but were unsuccessful. There was some delay before nurses arrived at the cell. It is not possible to say that, had they arrived earlier, things might have been different. I make three recommendations in respect of lines of communication at Wakefield.

The Deputy Governor, in charge of Wakefield during the absence of the Governor, tried to trace the man's next of kin. The man had given the name of his brother who lived in Scotland. However, the man's brother had moved and the telephone number was not available to the prison. Neither was his address. It was the next day when the police traced the man's brother and gave the Deputy Governor two telephone numbers. The second of these proved to be correct. The Deputy Governor telephoned the man's brother and broke the sad news. The man's brother remains unhappy both at the time it took to trace him, and the manner in which he was told of the man's death. The Deputy Governor told my investigators that he made sure the man was not alone at home when he broke the news. The man's brother does not recall the Deputy Governor asking this question. He told my investigator and family liaison officer that he would have preferred the police to visit and break the news. He felt also that the prison authorities should have had his mobile telephone number to hand. The man had not spoken to his brother for about 9 months by telephone and he had not updated official information in respect of either his brother's telephone number or address. The Deputy Governor told my investigators that the only number and address they had was the one in Scotland which the man's brother had left several years earlier

I understand why the man's brother feels as he does. There was, however, no easy way to break the news of his sudden death to his relatives. More than 12 hours had passed since the man's death, and the Deputy Governor was afraid that his brother might hear the news through the media. Both the man's brother and his partner told my investigator also that he had not given the man details of his present address, his partner was afraid that one day he would turn up at their home. They said however that the man had details of their previous address and the trail should have started there. In fact police did visit this address, which in their report to the prison said 'appears to be unoccupied'. They later traced the man's brother to his present address and were on their way to see him when the Deputy Governor telephoned.

The man's brother also asked why the man was not on continuous watch following his self-harming on the evening he died. The healthcare officer who treated the man that evening, and who knew him well, talked to him. He said he felt better, gave the officer the razor blade with which he had cut himself and promised he would not hurt himself again that night. The officer's judgement that an intermittent watch, with checks four times an hour, was, in my view, reasonable in the circumstances.

It is impossible to say what the man's intentions were when he wrapped a bed sheet around his neck. He was troubled generally, and he had harmed himself many times over the years. On the evening in question, he was particularly upset. It is possible that he intended not to end his life, but to bring attention to himself. It is possible also that the accumulation of years of imprisonment had left him with little hope for his future.

2. Investigation methodology

The investigation was opened on 24 March when my investigator and assisting investigator met with the Deputy Governor and Safer Custody Manager at Wakefield. (The Governor was on annual leave. He met the investigators immediately on his return to duty.) My investigators were given a comprehensive and very helpful briefing by the Deputy Governor on the events leading up to and following the man's death.

Ombudsman's notices, identifying the scope and methodology of the investigation, were issued to staff and prisoners. The notices also made clear that staff or prisoners who wished to see the investigators should make themselves known by either contacting the investigators' liaison officer at the prison, or by contacting my office direct.

Staff and prisoners in key positions or locations were identified by the investigators and were invited for interview. All responded willingly.

The local branch of the Prison Officers' Association (POA) were briefed. They were helpful and offered constructive comment and advice. The investigators also met with the Chair of the prison's Independent Monitoring Board (IMB). His contribution gave a helpful perspective on the prison.

During four follow-up visits, my investigators interviewed seven members of staff and six prisoners. Two prisoners wrote letters to my investigators, and one prisoner sent a letter to HM Chief Inspector of Prisons. This letter was passed to the investigators. All letters were answered, and the prisoners invited for interview.

The investigators met local police at the prison. They shared freely all their information and interview records, as did the coroner's officer.

The investigators commissioned an independent clinical review. This was conducted by the Primary Care Trust.

My investigator, together with one of my family liaison officers, met with the man's brother and his partner, at their home. They were made to feel very welcome. The man's brother gave them a valuable insight into his early life

3. The man

The man was born in Glasgow. His mother died when he was three. Following her death, the family home was destroyed in an arson attack. He and his brother were taken into the care of the local authority and went to live in a children's home. When the man was 15 and-a-half years old, his brother, then aged 17, joined the merchant navy.

The man had one brother and four half brothers and sisters. His father died aged 76 in 1994. At the time of his own death at the age of 37, the man had lost touch with all members of his family except for his brother.

The man's troubles started when he moved to London in the mid-1980s. From then on, he was regularly in conflict with the law. He had one stable relationship with a woman friend. When the friendship broke up, things got worse. Drink and drugs were significant in his life, and the man had served custodial sentences as a young person and as an adult. Between 1991 and 1994, he was subject to a Hospital Order imposed under the Mental Health Act 1983.

The man had not seen any member of his family since his Broadmoor days, and he had spoken just once in recent years by telephone to his brother. This was at the end of summer 2004. He had no details of his brother's current address, as his brother and partner had decided not to let him know the address to which they had moved.

In 1991, the man was sentenced to three-and-a-half year's imprisonment for robbery. The sentence was later converted under the Mental Health Act 1983 to a hospital order and he was transferred to a Special Hospital. At the Special Hospital, the man was not an easy patient and in September 1994 he was sent to Broadmoor. Whilst there, the man assaulted staff and patients and in a final incident he stabbed a fellow patient and threw boiling water on him. He believed the patient to be guilty of sexual offences against children. The man was charged with attempted murder. A report submitted to court by the Director of Medical Services at Broadmoor described him as suffering from an untreatable mental illness and recommended that he be transferred to prison. A probation officer's report to court said that the man had built up hatred for sex offenders and for those who offended against women. He received a life sentence on 6 October 1995 and he was sent to prison. He was serving this sentence as a category A prisoner at the time of his death.

During his sentence, the man lived in several high security prisons. Having regard to his temperament, it was not easy for prison staff to ensure either his safety or that of other prisoners, and there were many incidents. The man arrived at Wakefield in June 2002. He spent periods on mainstream location, but was segregated many times in the interests of good order and discipline (prison rule 45). He also spent periods as a patient in the prison health care centre, as he had done at all his other prisons.

The man harmed himself many times. Following each event, staff counselled him, prescribed medication and worked hard to support him through his bad periods. Two or three members of staff particularly kept him afloat, in particular the Healthcare Senior

Officer who had known the man at Frankland prison and who attended his funeral. It was gratifying to hear several prisoners who were interviewed by my investigators say how kind Wakefield staff were to the man.

On several occasions, plans were made to help the man live at peace with himself and with others. He was a willing participant in action plans, and there were periods when he felt well enough to go to work in the prison, and to attend education classes where reports of his effort and conduct were unfailingly good. When he felt well, he looked optimistically at the world and his future in it. When he was ill or depressed, he simply could not cope.

The man was supported throughout by Wakefield staff. He had regular medical consultations and he was prescribed drugs for his condition. He was counselled. He did not always take his prescription medication and, by his own account, sometimes acquired and took illegal drugs in the prison.

Prison reports to the Parole Board in 1998 described the man's continuing self-harm. It was not possible to recommend release within the foreseeable future. In 2001, the Parole Board noted a pattern of diminishing violence. Having spent 16 months in a drug rehabilitation unit in HM Prison Long Lartin, he had been clear of disciplinary trouble for two years. The Board noted that the man 'seemed to do well in prison hospitals'. There was no recommendation for release or change of security category. Subsequent reviews of his case for parole or lessening of security category noted regression and continuing significant risk to others in prison, and to the public. On 9 July 2004, the Parole Board's parole refusal letter said 'There is much work to be done on areas of risk...' A new review date was set for July 2006

The Category A Committee decided on 13 July 2004 that the man should remain Category A.

The man was visited just twice in Wakefield. The visits were for legal reasons and coincided with the preparation of parole applications. The last recorded visits were on 26 February and 9 March 2004. The man wrote three letters in recent times, the first to his brother in Scotland. That letter was returned as his brother had moved house and had not given him his new address. The second and third letters were to women friends. Neither of those letters received replies.

4. HMP Wakefield

HMP Wakefield was built originally in 1594 as a house of correction. The current prison buildings date from the 1850s. Wakefield is part of the high security estate designed to hold prisoners of the highest security category. For many years, Wakefield has specialised in the security and care of life sentence prisoners. It also has a focus on the treatment of serious sex offenders.

Wakefield is undergoing a programme of refurbishment during which a quarter of the accommodation is taken out of use to bring it up to modern standards. The last wing, A wing, is nearing completion. At the time of my investigation, Wakefield held 760 prisoners

Training and education courses for prisoners at Wakefield include full and part-time education, drug rehabilitation and alcohol education. There are courses for prisoners to learn to understand reasons for their offending behaviour, together with a sophisticated sex offender programme. There is also industrial work in well equipped workshops.

Wakefield is subject currently to a Prison Service programme known as Performance Improvement Planning. This programme helps a prison assessed as level 1 or 2 (on a 4 point scale, with 4 points being the best rating) to improve its performance. A team led by the Deputy Director General reviews all aspects of delivery and sets new targets which challenge the establishment to tackle specific areas for improvement. The establishment is given support to develop an implementation plan setting out how the improvements will be achieved.

Wakefield operates a dynamic and comprehensive Suicide Prevention Strategy. The Policy document is revised every year, the last revision being in January 2005. There is an active Suicide Prevention Co-ordinator who heads a team of trained Suicide Prevention and Anti-Bullying officers. The decision to combine suicide prevention and anti-bullying was made about two years ago, recognising the close link. HM Chief Inspector of Prisons, in her report of October 2003, praised this practice, commenting that results were 'positive, effective and emphasised the strong leadership and high priority given to suicide prevention'.

The Chief Inspector's report recognised other areas of good practice, including the interview given by Suicide Prevention and Anti-bullying officers to all new receptions, checks by a governor on documents when a prisoner is taken off special suicide watch, and the seven and 14 day follow-up checks which follow. The Independent Monitoring Board in its 2004 report commented on the excellent way in which the system operated.

The Suicide Prevention Team meets every two months. My investigators reviewed the minutes of the meetings and found that prisoners are monitored diligently and comprehensively. A report is given by the Suicide Prevention Co-ordinator, all open suicide and self-harm files are scrutinised and - where the team has concerns in respect of any prisoners - an action plan is agreed. Notices and reminders to staff are produced regularly in order to ensure that they never forget the importance of suicide awareness.

Wakefield has an enviable drugs testing results performance. Mandatory random testing of prisoners yields positive findings of less than 1%.

The death of the man was the fourth apparently self-inflicted death to have occurred at Wakefield in just over a year.

5. Events leading up to the man's death

At the time of his death, the man was located in C wing. During the previous twelve months, as well as living in ordinary accommodation, he had from time to time been located in a special cell with closed circuit television, in the healthcare centre, and in the segregation unit.

In the year before he died, the man was the subject of suicide and self-harm precautions on no fewer than 14 occasions. On four of those occasions, he had self harmed by cutting himself or by attempted asphyxiation. At other times, he said he had strong urges to hurt himself. Some of these suicide precautions were for short periods, sometimes for as little as three days. The man's comments and threats were often made when he was moved away from the environment of the health care centre to mainstream accommodation.

The man regularly achieved moves to the health care centre by deliberate self-harm. Without doubt he felt better there. Health care staff who treated him felt that his stress and threats were the result of genuine concerns and fears brought on by his serious mental problems. On each occasion when the man was subject to a suicide and self-harm watch, detailed notes show that his state of physical and mental health was carefully monitored. Many written notes show that staff took opportunities to talk to him, to support him and to help him through his stress.

In the summer of 2004, during a spell when the man was a patient in the health care centre, he was overheard (and later admitted) making threats to kill another patient. A plan was drawn up by the clinical and other support staff to manage his life outside the confines of the health care centre. Health care staff would continue to take an active interest in him. The man signed up to the plan. He was prepared to try to live a full life on ordinary location.

In the autumn and winter of 2004, the man spent periods on C wing and in the B wing camera cell. Towards the end of the year, he became unsettled and medical staff described him as 'more paranoid and forgetful'. When he felt good he was generally all right on the wing, but when he felt bad there were problems. Both staff and prisoners said that he was given a lot of latitude. A quote from the record says '[the man] is on enhanced privileges more because of the patience and understanding of staff than anything else.'

My investigators interviewed several prisoners who knew the man. He had a few close friends. All said he was either 'up' or 'down'. There was no middle ground. In one breath he would be on top of the world - 'I've saved over £20' - and in another he would be without hope - 'I'll never get out of prison.'

On 17 January 2005, the man moved to D wing where he stayed for about a week before being admitted to health care, initially for review, but subsequently as a patient. He stayed for about six weeks. By this time he had reconciled his differences with the patient against whom he had made threats, and they became friends.

On 31 January, the man said he had been sexually assaulted by other prisoners prior to his admission to the health care centre. Police investigated, but found no evidence of assault. Medical evidence showed that an assault could not have taken place. The man said later that he had imagined the incident and that he had not been assaulted.

The man remained a patient in health care until 2 March, and then moved to C wing. He was back in health care within two days, staying this time until 18 March when another plan was drawn up for his care on mainstream location. At about 6.25pm on 20 March, the man made several superficial cuts to his arms. He told his wing officer that he was afraid to leave the wing as he had received threats from prisoners. The officer reported, 'he told me he wanted to string himself up'. The wing officer set in train the formal self harm and suicide prevention process (form F2052SH). The effect of this was to ensure that the man's health would be checked regularly by wing staff, records would be kept, and action taken if the risk escalated of him hurting himself. Immediately after cutting his arm, the man was treated by the healthcare officer who bandaged his arm and spent some time examining and reassuring him. The man told the healthcare officer that he was feeling much better. The healthcare officer left the man's cell at about 6.55pm.

At 7.05pm, just ten minutes after the healthcare officer had left C wing, the wing officer looked through the observation panel in the man's cell and saw him hanging from a noose made from a torn bed sheet. The sheet was attached to the bars on the cell window.

There was no delay entering the cell. Staff knew the man and had no reason to wait for assistance. The wing officer unlocked the door immediately and called to an officer who was also on duty in the wing. Other staff attended and both wing staff and nurses tried to revive the man. The wing officer and the officer also on duty supported the man's weight, removed the ligature and immediately took on the work of trying to revive him. The wing officer tried to establish an airway and he gave mouth to mouth resuscitation. The principal officer arrived quickly and she assisted in the emergency treatment.

Both the principal officer and the wing officer continued to give mouth-to-mouth resuscitation to the man despite the absence of protective masks. The man had vomited and I do not need to go into details of the difficulties this presented. Despite this, they carried on attempting to revive him. I make a recommendation below in respect of the wing officer's efforts and those of the principal officer. Their actions were a credit to themselves, to their prison, and to the Prison Service as a whole.

The officer also on duty tried to send an emergency radio message to the Communications Centre, but his radio would not work. Radios are checked routinely at the start of an officer's tour of duty and at regular periods throughout, by a series of test calls which can be initiated by either the officer or the communications centre. Infrequently a transmission will be prevented by a 'blind spot' in the communication channel and it is likely that this occurred when the other officer also on duty tried to raise the alarm by radio. The radio network is the normal way of passing urgent messages and it enables the communications officer to call for specialist help as required. When his radio failed, the other officer on duty did not have time to go to the office and use the telephone as he was

helping in the attempt to revive the man. He ran out of the cell and activated an emergency general alarm button on the landing wall.

Alarms are activated when serious incidents occur (fire, serious injury and in any circumstances when a number of staff may be required to attend). When a general alarm is activated, the location is identified through an electronic signal to a communications centre some distance from the scene. The communications officer has no way of knowing the nature of the emergency. The indicator will show a general location, in this case 'C wing level 3'. The communications officer transmits a radio call, notifying staff of the alarm activation and its location. Staff attend, make an assessment of need, and request assistance as appropriate. If the alarm is activated in a prison wing, a bell and a warning light will operate additionally in the wing office, as it did in this case. Thus, it is likely that staff in the wing will attend, together with staff who have heard the radio alert from the communications officer.

Healthcare staff, on hearing of the alarm through their radio, and knowing that prisoners were all locked in their cells, had no way of knowing the alarm was for medical reasons. When the communications officer established that a medical response was needed, he did not use the radio to alert nursing staff. Instead he telephoned the health care centre. The call was taken by a non-nursing member of staff on duty in the health care centre. He immediately told the nurses that a prisoner was hanging in C wing. The nurses telephoned the communications centre for clarification. They were given the same message. They collected emergency equipment and went to C wing. They arrived there between ten and twenty minutes after the man had been found. Valuable time was lost. It is not possible to say whether or not the earlier attendance of nursing staff would have changed the course of events but it could be vital in another situation. I make a recommendation below.

Nursing staff took over the man's care. The emergency ambulance arrived at 7.25pm and paramedics continued to try to resuscitate him. Sadly, they were unsuccessful and the man was certified dead at 7.37pm. Everyone left the cell and the door was locked. It remained secure until the Duty Governor entered with a medical officer at the prison. The man was examined by the prison medical officer who had nothing to add to the diagnosis made earlier by paramedics.

6. Events following the man's death

Wakefield's contingency plan was activated. Police arrived quickly and the coroner's officer was notified. The duty governor followed the procedures laid down for action when a prisoner has died and she did everything well and in good time.

It was difficult for the duty governor to find details of the man's immediate family. Next of kin details showed a Glasgow number for the man's brother. His brother had in fact moved from Scotland two years earlier. It is understood that the man knew this but had not updated staff. In any case, he did not know his brother's new address.

Wakefield's Deputy Governor, tried to trace the man's brother through the police, but the address was five years old. By the morning after the man's death, the police had narrowed the search and gave the Deputy Governor two telephone numbers. The second number proved to be that of the man's brother.

Having established that he was not alone, the Deputy Governor broke the news. The man's brother was distressed and rang off. The Deputy Governor telephoned again and spoke to the partner of the man's brother, and then again to the man's brother. He explained the procedure for investigation and the inquest, and gave him telephone numbers for himself and the police. The Duty Governor on the day the man died spoke in the afternoon to the man's brother, and she gave details of the undertaker. The Duty Governor asked the man's brother if he would like to visit the prison. He said not but asked for the man's personal effects to be sent to his home. The man's brother telephoned the day after. He was again distressed as he had no money to pay for a funeral. The Deputy Governor reassured him and advised him of the arrangement where the prison could pay. The man's brother accepted this offer. The man's brother recollection is that he had to seek the coroner's intervention in persuading the prison to meet the funeral costs. My investigator spoke on 24 March 2005 to the Deputy Governor, who assured him that during a discussion with the man's brother, he made it plain that the prison could meet the funeral costs.

Representatives from the prison attended the man's funeral, including the Chaplain who spoke at the service and two health care staff who had known the man well.

The Deputy Governor held a meeting next morning to discuss the man's death. This meeting, known as a 'hot de-brief', is held following every major incident in any prison. The aim is to establish, while the details are fresh in the minds of staff who have been involved, if there are lessons to learn. It also serves as a check on how staff are feeling, having gone through a very difficult experience. Thus the Deputy Governor was able to see, and hear for himself, accounts from all the staff, and to review the information available at that early stage.

Except for the nurses, the Deputy Governor personally saw all staff that had attended C wing the evening before and tried to revive the man. The omission of the nurses was unfortunate. The nurses were asked if they would like to see the team responsible for staff

care (Care Team) and they said they were all right and needed no support. They were nevertheless unhappy that they had not been called to the meeting held next day, and they expressed their concern in writing to the medical officer and to the duty governor. The nurses should have attended the meeting. They had much to contribute. (The nurses have now had the opportunity to contribute to the learning points.)

7. Clinical Review

The clinical review, carried out by representatives of the Primary Care Trust, found that the man was treated sympathetically and skilfully by Wakefield staff. The review identified six areas of good health care practice at Wakefield:

1. Psychiatric nursing care delivery by the prison's nursing team and CPA coordinator.
2. Psychiatry treatment plans and reviews by local psychiatrists from the Mental Health NHS Trust.
3. Clinical psychology assessments and interventions by the prison's clinical psychologist.
4. Operation of risk assessment tools to manage risk in a variety of areas, e.g. in-possession medication, shared accommodation, segregation safety etc.
5. Key worker/named healthcare worker system operating in the Healthcare centre inpatients unit.
6. Multi professional and inter-departmental behavioural management plans, which despite their complexity were effectively communicated between disciplines.

The clinical review said that health care staff should consider how they can disseminate their best practice in caring for difficult to manage, high security prisoners with behavioural and mental health problems, e.g. in case reviews in professional journals.

The review included two further recommendations that are reproduced in the list in section 9 below.

8. Conclusions

The man was serving a life sentence as a high security prisoner. The Parole Board had concluded that the risk to the public was too great to contemplate his release. He would have been conscious of the many years he would have continued to face before his release.

The man did not thrive in prison. My investigators heard many accounts about him and the way he dealt with imprisonment. On a good day he was able to engage in normal life, eating with friends, attending education classes and working hard. However, on a bad day he was either full of despair or implied violence and it was difficult for both staff and prisoners to keep him and others safe. One comment which ran consistently through the investigation interview reports and informal conversations was: 'The man should not have been in prison. He should have been in a Secure Hospital.' But wherever he lived, it would have been difficult to find a safe haven in which he could live his life without risk to himself or others.

Wakefield's decision to plan the man's care around ordinary location on the wing was sound. He could not live indefinitely in the health care centre. In any case, he was not always content there, and the prison had to consider the needs of other patients.

Staff and prisoner friends were sympathetic and supportive. My investigators found that staff did all they could to help him lead his life on an even keel. Some staff took a keen and personal interest in his welfare. They should not reproach themselves for the sad circumstances of the man's death.

It is not possible for me to say what the man's intentions were when he wrapped a bed sheet round his neck or what motivated his actions. He had harmed himself many times in the past, and on some of these occasions he had come near to death.

My investigation has found that the man was troubled and often depressed. Sometimes he appeared to see a glimmer of hope for his future, but despair was never far from his mind. This was a sad end to an unhappy life.

9. Recommendations

Health

1. Health care staff should be given clear written instructions identifying the need for quick response in the event of an emergency. It is not necessary to make a telephone call to confirm when they have already been told the nature of an incident in unambiguous terms.
2. Healthcare management should review the frequency of nurses making written entries in the nursing notes and consider increasing them from a daily entry to a written entry for each shift, i.e. morning, afternoon, evening, and night.
3. Healthcare management should put in place a system of clinical record keeping audit, particularly pertaining to the medical record and doctors' entries.

Operational

4. The principal officer, wing officer and senior officer should be commended by the Prison Service for their actions in trying to revive the man.
5. The Governor should remind his senior colleagues that all staff involved in serious incidents should be called to attend the 'hot de-brief' meeting.
6. Wakefield should have a single radio call sign to be used to alert health care staff to the need for emergency attendance. The present arrangement, which depends on what time of day either call sign is used, is capable of misinterpretation.
7. Communications staff should be advised that the radio is the appropriate means to advise health care staff when emergency attendance is required.