PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man whilst in the custody of HMP Wayland in February 2012

Report by the Prisons and Probation Ombudsman for England and Wales

September 2012

This is a report into the death of a recalled prisoner at HMP Wayland, in February 2012. He had been in custody since July 2011 and transferred to Wayland in November 2011. I would like to offer my condolences to his family for their loss and to all those that were touched by his death.

One of my investigators conducted the investigation. A clinical reviewer was commissioned to review into the standard of healthcare the man received in custody. Wayland cooperated fully with the investigation.

The man had little contact with the healthcare services in prison and no previous history of self-harm. The mental health team at HMP Bedford concluded he had no mental health problems and his only contact with healthcare staff at Wayland was during the reception process. The clinical reviewer raises no substantial issues regarding his healthcare.

Despite being found two different forms of employment, the man subsequently refused to work. He spent most of his time in his cell in his nightwear and appears to have become quite reclusive. He mixed with a small group of prisoners and spoke to his friends about his failing relationship and his frustration at being in custody but neither he nor they raised any concerns with staff about his feelings or behaviour, even when he gave away some of his possessions shortly before his death. Staff do not appear to have noticed his withdrawal from the regime.

On the day the man died, prison staff found him hanging from the light fitting in his cell by a belt, which he had placed around his neck. Prison staff and, later, paramedics were unsuccessful in their attempts at resuscitation.

The investigation has not been able to find evidence that the man's death could reasonably have been foreseen by staff. However, when he began to disengage with the daily regime, it does appear that staff on his wing should have done more to find out his reasons for doing so. Accordingly, the investigation identifies some scope for improvements, particularly in the way that the personal officer scheme operates at Wayland.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2012**

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SUMMARY

1. The man was recalled to prison in July 2011 and received into HMP Bedford. On his arrival into custody, prison staff completed a medical healthscreen which indicated that he had no physical or mental health problems. When asked, he said he had no thoughts of self-harm. He disclosed that he had used cannabis regularly in the past, but had not used drugs intravenously. He declined to see a general practitioner (GP).

2. On 27 September, at an appointment with the prison doctor, the man said that he was feeling down and miserable and having trouble adjusting to another prison sentence. As a result, the doctor referred him to the prison's mental health in-reach team (MHIRT). The clinical reviewer questioned whether such a referral was appropriate. The mental health assessment concluded that there was no thought disorder, psychosis or self-neglect and no evidence of mental illness. The man also denied any thoughts of self-harm. The MHIRT discharged him after a follow up appointment mid-October. At an appointment with a prison GP in 20 October, he was prescribed a four-day course of medication to help him to re-establish his sleep pattern.

3. The man transferred to HMP Wayland on 16 November. The reception health screen recorded that there was no mental health history, no physical health concerns and no thoughts of self-harm. The reception nurse was aware of the man's interaction with the medical staff at Bedford and this was his only contact with the healthcare department at Wayland.

4. The man got a job in the prison kitchen, but only attended for one session. Sentenced prisoners at Wayland are required to work and staff allocated him to another job, in waste management. He again declined to attend. His friends said he spent most of time in his cell and mixed with a small group of his peers. Staff warned the man about not working, but did not explore the reasons for his continued refusal to do so or to engage with the regime. They recorded little information about him.

5. On the day the man died during the evening count of prisoners, a member of the night staff saw him hanging by a belt from the light fitting.
No healthcare staff are on duty at night, so prison staff administered cardiopulmonary resuscitation (CPR) while they awaited a first responder and paramedics. The man did not respond to the resuscitation attempts and ambulance staff pronounced him dead.

6. The investigation has concluded that, while the man's death was not foreseeable, more could have been done by staff to enquire about his well-being and reasons for not engaging with the regime. We believe that improvements are necessary in the operation of the personal officer system at Wayland and that mental health awareness training would benefit prison staff. We have made recommendations on both these matters.

THE INVESTIGATION PROCESS

7. The investigator carried out the investigation. He contacted HMP Wayland and arranged for the man's prison and medical records to be made available. He visited Wayland initially on 16 February and spoke with staff and prisoners who had known the man. Notices were issued to staff and prisoners to inform them of the investigation and invite them to provide relevant information about the man. A number of prisoners indicated that they would be willing to speak to the investigator.

8. Norfolk and Waveney PCT commissioned a review of the medical care given to the man while in custody. The clinical reviewer completed this review on their behalf. She interviewed staff jointly with the investigator. The clinical review report was received on 12 July 2012.

9. One of our family liaison officers (FLO) contacted the man's mother, his nominated next of kin on 16 February to explain the role of the Ombudsman. The FL0, another family liaison officer and the investigator visited the family to explain the investigation process and discuss their concerns about the man's death and his care in custody. They raised several points of concern. Those relevant to his management and death have been considered during the investigation.

10. The family explained that they had been told, after the man's death, that he had given away items of his property. Also, that the man had photographs displayed in his cell and his friends had told the family that he had removed them prior to his death. Concerns were also raised about a message written by the man on his cell wall and e-mails he received from his girlfriend. While some of the points raised by the man's family are addressed in this report, others have been dealt with by our family liaison officer in correspondence.

11. Following the issue of the draft report the man's family raised a number of questions, which have been answered in correspondence. The family also requested documentation, which was considered during the investigation, this has been made available.

12. The investigator returned to Wayland on 16 and 17 April, where he interviewed seven members of staff, jointly with the clinical reviewer. He also interviewed three prisoners who had known the man.

13. The investigator informed HM Coroner of the investigation and requested a copy of the post mortem and toxicology reports, which he received on 19 April.

HMP WAYLAND

14. HMP Wayland is a category C prison in Norfolk. (Prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. Category C prisoners are defined as those who cannot be trusted in open prison conditions but who would not have the ability or resources to make a determined escape.) It opened in 1985, and comprises 13 residential units, with the capacity for up to 1017 prisoners.

15. D wing, where the man lived, provides treatment for drug and alcohol dependency. However, the man was located on this wing due to limited space and was not under treatment.

16. There is nursing cover in the prison between 7.30am and 7.30pm. If healthcare is required at other times, the local out-of-hours service is used.

Previous deaths at Wayland

17. Since this office took over responsibility for investigating deaths in prison custody in 2004, seven prisoners have died at HMP Wayland (six occurred before the man's death). Five of these deaths were due to natural causes. One former prisoner also died the day after his release from Wayland. In an earlier investigation at Wayland, we commented on the time taken by the emergency services to arrive at the prison. In this case, there was also a delay owing to bad weather.

Her Majesty's Inspectorate of Prisons

18. The Inspectorate's last report on HMP Wayland followed an announced inspection in June 2011. The inspection found that Wayland was "generally a safe prison". However, healthcare was not well managed, and access to the range of services was inadequate for the needs of the population:

> "There were wider problems with the provision of health services in the prison. Strategic management of health care was poor and partnership arrangements were weak. Staff shortages had a detrimental effect on the care of prisoners … "

19. The report also noted that GP services were reliant on locum staff. The self-harm and suicide prevention policy was said to be well managed.

Independent Monitoring Board (IMB)

20. Each prison in England and Wales has an Independent Monitoring Board, made up of unpaid volunteers from the community who are appointed by the Secretary of State for Justice. They are responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained.

21. The last report published by the IMB at Wayland said that it was "a first rate prison". However, the Board made criticisms of Wayland's healthcare services. The report said:

> "Within this reporting year Serco took over the Healthcare contract. The complete management failure of Serco within Healthcare and the IDTS programme has greatly affected many regimes in the prison … The Board fully recognises the hard work and dedication of the staff, no more than those in Healthcare, but they are put under extreme pressure because of staff shortages beyond their control … since SERCO were awarded the new contract, services have deteriorated"

Counselling, Advice, Referral and Throughcare services (CARATs)

22. The Counselling Assessment Referral Advice and Throughcare service team provides an assessment and sign-posting service for prisoners with drug and alcohol problems. The team works in partnership with the healthcare service and discipline staff to provide a service within the prison and as a referral agency for ongoing support to prisoners on their release.

Integrated Drug Treatment Service (IDTS)

23. The integrated drug treatment system (IDTS) aims to increase the volume and quality of substance misuse treatment available to prisoners, with particular emphasis on:

- early custody;
- improving the integration between clinical and CARAT Services; and
- reinforcing continuity of care from the community into prison, between prisons, and on release into the community.

Personal Officer Scheme

24. The personal officer scheme is a nationally devised policy but each prison has its own way of delivering the scheme. A certain number of prisoners are allocated to a named officer to whom they can go for advice or to resolve complaints. The officer completes reports on prisoners for whom they are responsible, ensures entries are made in their wing history files and offers general advice.

Incentives and Earned Privileges scheme (IEP)

25. The Incentives and Earned Privileges scheme aims to encourage and reward good behaviour in prisons. Governors have devolved responsibility to draw up their own schemes however, the scheme must operate on at least three tiers: Basic, Standard and Enhanced. Prisoners move between levels according to their behaviour and performance. The key earnable privileges/incentives are extra and improved visits, eligibility to earn higher rates of pay, access to in-cell television, opportunity to wear own clothes, more private cash to spend and time out of cell for association. In addition to the key earnable privileges,

prisons may make other privileges and incentives available to suitable prisoners according to local circumstances.

Cardiopulmonary resuscitation (CPR)

26. This is an emergency procedure, which is performed in an effort to manually preserve intact brain function until further measures are taken to restore spontaneous blood circulation and breathing, in a person in cardiac arrest.

Automated External Defibrillator (AED)

27. Defibrillators are portable units, used in life-threatening emergencies to analyse heart rhythm and advise whether a controlled electric shock is required. They are designed to be easy to use by non-medical persons, who require little training to operate them correctly. Trained health professionals, are able to diagnose and treat a wider range of problems with manual or semi-automatic units. For this reason, paramedics at an emergency usually replace the AED with their own equipment.

KEY EVENTS

28. The man was convicted and sentenced to 4 years imprisonment at Chelmsford Crown Court. He was released on licence from HMP Highpoint. However, he was recalled to prison after committing further offences while subject to licence conditions imposed on him under the terms of his release. His recall meant that he could expect to remain in custody until March 2014.

29. On his reception at HMP Bedford, a staff nursecompleted an initial health screen, in which he recorded the man's basic medical history. The nurse asked him if he wished to see the doctor, but he declined. He said that he did not feel suicidal and had no thoughts of self-harm. When asked about previous illicit drug use, the man said that he had used cannabis, but did not use drugs intravenously. He told the nurse that he had no concerns about his physical health and had never received treatment for mental health problems.

30. A secondary healthscreen was completed in July, to record the man's medical history in more depth. In addition, alcohol and mental health assessments were also carried out and there were no concerns in either area. The man told the nurse that he wished to give up smoking and a referral was made for him to be seen in a smoking cessation clinic.

31. The man was familiar with prison life and settled in quickly to the daily routine, gaining employment in the kitchens. In September, the Parole Board informed him that they had upheld the decision to recall him to prison, because he had committed further offences.

32. In September, the man attended an appointment with a prison GP. The GP recorded that the man said that he was feeling down and miserable, and was finding it difficult to adjust to another lengthy jail sentence. He told the GP that he had not felt this way on previous sentences. The GP advised him to think of positive things and focus on making the most of his time. The doctor recorded that there was no appropriate treatment at that time, but a referral was made for the man to be seen by a member of the prison's Mental Health In-Reach Team (MHIRT).

33. As a result of the referral, a Community Psychiatric Nurse (CPN) visited the man in October, to carry out a mental health assessment. The man told the nurse that, although he functioned normally during the day, he 'could feel no enjoyment.' He said that he was eating well, but was having trouble sleeping. The man said that the main problems had persisted for years and spoke of social and relationship issues, but he reported no apparent triggers for his feelings. They discussed his previous drug use and, although he had used cannabis, he did not consider himself an addict. It was suggested to the man that he tried involving himself in education or with CARATs to gain more stimulation, but he said that he had tried them all and did not find them useful. The nurse recorded that, as the assessment went along, it became difficult to explore further with the man as he became dismissive. He denied any thoughts of self-harm and said that his family were his protective factor, and that he was

'not that kind of person.' The nurse concluded that there was no evidence of any thought disorder, psychosis or self-neglect or of mental illness.

34. The psychiatric nurse followed up her initial assessment by visiting the man again in October. He said that he had continued to feel the same, but told her that he felt this was actually his 'normal self'. She again encouraged him to engage with the CARATs team, and on this occasion, he agreed that he would. The staff working in the kitchens where the man was employed expressed no concerns about him, when asked by the nurse. The man was asked about other types of support that he felt may be useful to him. He told the nurse that he continued to have difficulty sleeping and asked if he could be referred to the GP to discuss this. The nurse concluded that the man had no signs of mental illness so she discharged him from the MHIRT team, but referred him to be seen by the GP and CARATs team. At an appointment with a prison doctor in October, the man was prescribed a four-day course of medication to help him to re-establish his sleep pattern.

35. There are no further contacts recorded between the man and healthcare while he was at Bedford. In November, he transferred to HMP Wayland. A nurse completed a reception healthscreen. She recorded that there was no mental health history, no physical health concerns and the man denied any thoughts of self-harm.

36. The investigator and clinical reviewer asked the nurse whether she had been aware of the man's involvement with the MHIRT at Bedford during the health screen. She explained that when a prisoner is transferred in, she is unable to access their electronic medical record until it has been saved. She said that some prisoners might lie about their previous self-harm history or the types of medication that they have been prescribed. To assess the accuracy of information given by a prisoner, once she has completed the health screen she would save it on the computer and then reopen it, in order to access any previous entries.

37. The nurse said that she had no concerns about the man based on what he had told her during the screening process and, when she checked his record, found he had provided the same answers during earlier health screens. She also saw that the MHIRT at Bedford had assessed him on two occasions and they had no concerns. In view of this, she believed that the man had given her correct information. The investigator asked whether the man's involvement with the MHIRT at Bedford meant that a referral should have been made for him at Wayland, but the nurse said that this was not the case, as he had been discharged from their care and no concerns had been highlighted.

38. At Wayland, the Integrated Drug Treatment Service (IDTS) is provided on D wing, and the man was located there following his reception at Wayland. Although the wing is predominantly for prisoners undergoing detoxification treatment for drugs and alcohol, other prisoners are placed on the wing if space is not available elsewhere. This was the case when the man arrived at Wayland and he was not considered to require the services of the IDTS team.

39. As a sentenced prisoner, the man was required to work. As he had previously worked in the kitchen at Bedford, he was assigned the same job at Wayland. However, he attended for only one session. The investigator asked a kitchen worker at Wayland, why the man had not continued with his employment. The worker recalled that he had attended for a morning session, and then failed to return in the afternoon. When she had enquired about the reasons, she was told that it was due to the level of pay. He had received a higher pay rate for the same work at Bedford and was reluctant to continue.

40. The man was an 'enhanced' prisoner under the incentives and earned privileges (IEP) scheme. As he was no longer in employment, staff warned him that there would be a review of his status with a view to reducing it to 'standard'. The investigator was told that all sentenced prisoners are required to be employed and to meet the requirements of an 'enhanced' prisoner this must be maintained. It was normal practice to review the IEP status if a prisoner refused to work.

41. However, before an IEP review took place, the man was given alternative employment, in 'waste management', collecting rubbish and emptying bins around the prison. The investigator was told by other prisoners that this is a sought after position during the summer, but is not such a great job in the colder weather. The man continued with this job initially, but in January, he was again given a warning for failing to attend for work, and his employment was eventually terminated after he continued to refuse to attend.

42. The man's personal officer said that each officer is allocated around ten cells and they act as the personal officer to the occupants of those cells. The personal officer made an entry in the man's case notes to indicate that, as he was no longer employed, he should be downgraded on the IEP scheme. The officer explained to the investigator the process for reviewing a prisoner's IEP level and the requirements for the personal officer. He confirmed that an unemployed prisoner would not be 'enhanced'. He recalled the man had failed to attend work in the kitchens on three occasions so as his personal officer he had completed a report to the wing manager to reduce the man's status. They did not take this action immediately in view of the alternative employment provided.

43. Around the same time that the personal officer was dealing with the refusal to work, the man also gave him an application to transfer to HMP Blantyre House. He gave no reasons for his request. The person officer told the investigator that he completed and submitted the necessary forms on his behalf. He recalled talking to the man at other times and described him as 'generally a bit lazy'.

44. Prisons use an electronic database known as P-NOMIS and each prisoner has a case file on this system. Staff, particularly personal officers, are expected to use a prisoner's case notes to record interactions, inform other staff of concerns or record the general behaviour of an individual. Very little was recorded about the man and there is no evidence that staff pursued with him his reasons for not engaging with the prison regime.

45. The investigator interviewed Officer A, who also works regularly on D wing. She described the man as a 'very quiet individual who got on well with staff and would not draw attention to himself'. The officer had also recorded on the man's case notes that he had refused to attend work and recommended that he was reduced to 'standard' level. The officer said that she could not specifically recall the issues, but said that she was aware that the man was not keen on attending work and would laugh with staff about this. She recalled the man saying that he could not be bothered when he was asked about not going to work. The officer was not aware of any other reasons why the man did not attend for work, such as problems with other prisoners.

46. Once he lost his job in waste management, the man refused all other opportunities to work, and would spend most days in his cell. The investigator interviewed prisoner A, a friend of the man's.

47. Prisoner A described the man as 'quite quiet' and said that he did not mix very much with other prisoners. The man would openly talk to staff and approach them if he needed anything. The investigator asked whether the man engaged with the daily routines on the wing and used the facilities that were available to him, but he said that the man never used the gymnasium and, when unlocked to associate on the wing, he would mostly sit in either his own cell, or that of his.

48. The investigator asked prisoner A if he was aware of the man's reasons for not working. He replied that at Bedford the man had worked in the kitchens, and had been assigned to do the same at Wayland. He confirmed that the man had completed one session, but due to the wages had not continued. He added that the man became 'a bit of a hermit'. Usually, he would not get out of bed before 11.00am, and they would joke about this. He would often say to the man that he was becoming 'wing bound' and should get out for some fresh air, but he seemed happy with his own routine and did not wish to work. Prisoner A also told the investigator that the normal procedure is that those who refuse to work are confined to their cells during the day. However, this did not apply to the man and his door would be left open, which they joked about. The prisoner said that because of this he assumed that staff were happy with the reasons that he had given for not working.

49. The investigator asked prisoner A whether the man had spoken about anything that was bothering him. In his opinion, the man had been trying to deal with a number of issues. This included the breakdown of his relationship with his girlfriend, and his disappointment at being recalled to prison. However, the prisoner considered that these were very much like the problems other prisoners were dealing with and the man appeared to be handling them. He added that the man never gave the impression that these matters were bothering him and he would always laugh about things, although, with hindsight, he wondered if there had been an element of bravado.

50. The man's family had raised a concern that he had removed photographs displayed on his cell walls, before his death. Prisoner A could not recall ever seeing photographs displayed by the man. He was aware that he had photographs of his family as the man had offered to them to him, but he had never seen them displayed on the walls. The investigator asked other prisoners the same question and one said that he had seen photographs on the man's cell wall.

51. Prisoner B, another prisoner on D wing, knew the man. He said that the man was very quiet. He rarely left his cell and wore the same pair of pyjama bottoms throughout each day. He recalled that the man was on the telephone at every opportunity, also confirmed by prisoner A. Prisoner B was asked whether he considered the man vulnerable. He said that despite the man's limited contact with others, he did not consider him as vulnerable and although he kept himself to himself, he would go out and have a laugh and a joke with a small group on the wing. During the interview, prisoner B also explained that because of the location of the wing, there was little contact with officers during the course of the day.

52. The man made regular telephone calls to his girlfriend. The investigator listened to the recording of the calls. Despite telling his friends that he felt his relationship was over, the contents of the discussion suggest that his girlfriend was positive about their future. He also received regular e-mails from his girlfriend via the 'E-Mail a Prisoner Scheme'. The scheme is run by a company independent of the Prison Service and provides family and friends with an inbox to which they can send e-mails. They are then sent to prisons taking part in the scheme where they are printed and passed to prisoners in the same way as letters.

53. In January, the man submitted an application for additional credit on his telephone account, as he said that his stepdaughter was in Great Ormond Street Hospital. Senior Officer (SO) A, a manager on D wing, dealt with the application. He explained to the investigator that in the past managers had authorised too much credit for the prisoners' telephone and there were new instructions about the application process as well as information for managers on how credit should be authorised. In view of this, he contacted the hospital who confirmed that the man's stepdaughter had been discharged. He told the man that, because of this, a credit could not be authorised. The SO said that the man reacted fairly aggressively and did not appreciate the decision.

54. The investigator asked whether, the SO had any other concerns about the man's welfare at that time. He said that he had not. He acknowledged that prisoners react in different ways to situations and he had not had any issues with him previously.

55. In February, the SO completed a full yearly IEP review on the man. He explained that staff are required to conduct a full review on every prisoner at least once a year. This usually falls at the beginning of each year and the personal officer assesses each prisoner for whom they are responsible, using a matrix scoring system. They also comment on several other areas, including

cell cleanliness, attitude to the regime and work. The scores are 1, 2, 3, (good, average, poor) and indicate whether a prisoner should be upgraded or downgraded. If there is to be a change, the personal officer also has to complete a full review of the prisoner, including consideration of written evidence from their work area, security department and the offender management unit. The SO said that the man's feedback indicated that he should be on the 'standard' IEP level, but he would not have been notified of this until a governor had made the final decision.

56. During the day of the man's death, the man remained on D wing as usual. Prisoner A recalled speaking to the man during the morning and asking him if he was all right. He had said to the man 'you are not going to do anything silly'. The man just 'brushed this off' and said 'oh don't be silly.' Prisoner A was unable to explain why he had asked such a question, it was just spontaneous. The two prisoners then sat in his cell and had a cup of coffee and a cigarette, before prisoner A left the wing for work. He said that the man appeared the same as usual.

57. Prisoner A said that he, the man and a few other prisoners stood out on the landing that evening and were laughing and joking about some adult magazines. The man had given him no cause for concern. All prisoners were then locked in their cells at around 7.00pm.

58. On the evening of the man's death, an Operational Support Grade (OSG) was on night duty on D wing. Her role was to observe prisoners who were subject to suicide and self-harm prevention measures throughout the night, and respond to any problems raised by prisoners. The OSG was also required to conduct a full count of every prisoner at the beginning and end of her shift. At around 8.55pm, she began her count on the man's landing. On reaching his cell, she looked in via the observation panel. At first glance, the man appeared to be standing in the middle of the cell, but she then noticed he had something around his neck, which was attached to the light fitting. The OSG realised that the man was hanging and immediately went to the end of the landing, with the intention of using her radio to request assistance.

59. However, the OSG saw her colleague, Officer B, who had just finished his duty. She explained what she had seen and both staff returned to the man's cell. The officer used his radio to request 'urgent assistance.' The officer also looked through the observation panel. He saw the man suspended from the light fitting by a belt attached around his neck, and his feet were off the floor. He immediately opened the door and entered the cell. He passed his cut-down tool to the OSG and while he lifted the man, instructed her to cut the belt. The call from Officer B was recorded in the control room at 8.55pm, and a call to the ambulance service was made at that time.

60. As the OSG cut the ligature, Officer B lowered the man and laid him on the floor. The man's personal officer and officers C, D and E, arrived after hearing Officer B's request for assistance.

61. After 7.00pm in the evening, Wayland has no medical staff on duty, and emergencies are dealt with by the ambulance service or by contacting an out of hours medical service. In light of this, all staff are required to have knowledge of first aid and it is mandatory for all senior officers who act as the night manager to have recent first aid training.

62. The OSG had checked the man's airway and Officer B had begun cardiopulmonary resuscitation (CPR) when the other staff arrived. The man's personal officer took over giving chest compressions, and Officer D then relieved him so that he could collect the defibrillator (AED) from the D wing office. The man's personal officer returned with the defibrillator at 9.09pm and attached it to the man. The defibrillator indicated that there was no shockable rhythm and staff continued to administer CPR. All staff present rotated, administering chest compressions and breaths. They checked the defibrillator at intervals to see if any shockable rhythm could be detected, but it continued to advise 'no rhythm detected'.

63. When Officer B made the first call, the control room contacted the duty governor and duty principal officer (PO) at their homes to notify them of the emergency. Governor A and the PO arrived at the prison at 9.25pm and 9.34pm respectively. The governor went straight to the wing and was briefed by staff about the actions taken. Shortly after this at 9.34pm, the PO arrived and brought with him a paramedic first responder, who had arrived at the prison around the same time.

64. The paramedic first responder checked the man's vital signs while prison staff continued CPR, and he cleared the man's airway using a pump. He told the prison staff that the man's colour indicated they were conducting CPR correctly and encouraged them to continue. Governor A recalled at interview that, on one occasion, the defibrillator did pick up a rhythm and administered either one or two shocks at around 9.38pm, but staff then continued CPR. The paramedic first responder told staff that it was possible that the man had damaged his throat.

65. The investigator asked Governor A whether the paramedic first responder had administered any medication or drugs, such as adrenalin, to aid resuscitation of the man, while he was present. He replied that he had not been aware of the paramedic first responder giving any treatment, other than advising prison staff on what actions to take, and the only equipment he had was a portable heart monitor and pump.

66. At 9.50pm, an ambulance arrived with additional paramedics. This was 55 minutes after the request by the control room at Wayland. The ambulance staff then carried out further checks on the man, and again the defibrillator was checked, but indicated no output. After discussion, the ambulance staff decided to stop the resuscitation attempts and the man was pronounced dead at 9.59pm.

Actions following the man's death

67. Immediately after the man's death, Governor A held a debrief with the staff involved. Staff told the investigator that they felt the support offered to them had been good. The local police were also notified, as is normal practice and arrived at the prison at 11.15pm. The police viewed the cell and spoke to the staff.

68. Staff also offered support to prisoners on D wing. Prisoner A told the investigator that the local Samaritans were available on the wing to speak to prisoners. Also, wing staff constantly checked on them.

69. Staff checked the man's cell to identify any possible letters left by him to explain his actions. While no letter was discovered, a message had been written on the wall of the cell in black marker pen, which read 'sorry mum'. There was also a date '9/1 6 weeks'. The man's family did not understand the relevance of this and the investigation has been unable to clarify its meaning.

70. The prison appointed a family liaison officer and, along with a member of the chaplaincy team, left Wayland to notify the man's family at 11.50pm. The family liaison officer arrived at the home of the man's mother at around and notified her of her son's death. He gave the family as many facts about the man's death as were available at that time as well as contact details for himself and Governor A. The prison offered to meet the funeral expenses, and subsequently paid them. The family were also told that the PPO investigation would take place.

71. A memorial service was later arranged and attended by prisoners from D wing and staff. Prisoners told the investigator that they had found this helpful.

72. In February, the prison's family liaison officer received an e-mail from the man's stepfather explaining that the family felt let down, as they had been unable to contact him over the weekend. He contacted the family and explained that he had spoken to the man's grandfather on the Friday and, during that conversation, he had told him he would contact the family again on Monday. He apologised for the confusion. The man's family said that they wished to visit the prison and this was later arranged.

73. The prison's family liaison officer visited the family in order to return the man's personal belongings. During the visit, he explained that it appeared the man had given some items of his clothing away before his death. The man's family raised this as a concern, and asked why staff had not identified that their son was giving away his personal belongings, as it may have been an indication of what he was planning to do.

The man's property

74. During the investigation, the investigator asked staff about the searching procedures in place at Wayland. The SO explained that searching of prisoners' cells had become intelligence-led. Previously all cells would be searched during a month. The SO said that the new system gave searching 'more relevance'. He confirmed that under the new system, it would be feasible for a

prisoner never to be subject to a cell search. The man's cell had never been searched while he was at Wayland as he had never been suspected of involvement in anything of concern.

75. The SO said that in addition to cell searching, staff would go into a prisoner's cell each day to conduct a cell fabric check. The purpose of this check is to ensure that prisoners have not tampered with the walls, windows or door locks. Unlike a cell search, staff would not be necessarily looking for illicit items at these times. Also, staff would not be able to identify whether a prisoner was in possession of more or less property than they should have as prisoners have lockers in which to keep personal belongings.

76. The investigator asked the man's friend, prisoner A, whether he knew the man had given away his property. He said he did not become aware of any missing property until after the man's death. He had heard rumours from other prisoners that the man was giving away clothes that had an association with his girlfriend as he felt that their relationship was over. Other prisoners that submitted statements after the man's death had heard the same rumours.

77. Prisoner A was asked whether he felt that the man could have been pressured into giving items away. He was insistent that the man was not a 'weak person' or vulnerable and would have given the items away of his own free will. He speculated that he might have given them away as he was aware that if he was reduced to standard level, he would not be able to wear his own clothes and did not want to give them to prison staff. Another rumour was that the man had given his belongings away in exchange for tobacco. The prisoner said that this was feasible, as he would not have given them for away for nothing in return. However, the prison checked the man's previous goods orders and confirmed that he had regularly ordered tobacco.

78. Prisoner A said that once staff told the prisoners on D wing about the missing clothing, they made efforts to retrieve some of them. Eventually, the majority of the clothes were returned and the prison were able to hand these back to the man's family.

ISSUES

Medical care

79. The man had limited contact with the healthcare services in custody. At Bedford, he had told the GP that he was feeling down and having difficulty sleeping. The doctor referred him to the prison's mental health in-reach team (MHIRT) who gave him advice on coping strategies and encouraged him to contact the CARATs team. MHIRT held a follow up meeting a week later and discharged him from their caseload. The clinical reviewer questioned why a prisoner with anxiety and insomnia would be referred to the mental health in reach team as she would expect such symptoms to be dealt with by the primary mental health service. She makes a recommendation relevant to healthcare providers at HMP Bedford on this issue. This will be shared with them and followed up by Norfolk and Waveney NHS Trust.

80. Apart from the health screening conducted when he arrived at Wayland, The man had no other contact with nursing staff at the prison. The clinical reviewer found that the health screen conducted at Wayland was appropriate and all past medical history correctly recorded.

Emergency response

81. During the investigation, the timings and actions of the emergency services were not clear. The clinical reviewer requested further information and clarification on this from East Anglia Ambulance Service. She says the following in relation to the response of prison staff on the day the man died and emergency services:

> "… It is usual for category C prisons not to have 24 hour on site healthcare facilities. These prisons have access to a community out of hour's service. All Senior Officers at HMP Wayland have to be first aid trained since there is no healthcare cover in the prison overnight. The officers on duty at HMP Wayland on the evening of the man's death responded appropriately and effectively to the situation following The man's discovery. They commenced CPR, obtained a defibrillator and called for an ambulance.
>
> "Community first responders are sent by the East Anglian Ambulance Service control to life-threatening emergencies such as cardiac arrest. The responders live or work in an area and can get to an incident in just a few minutes while an ambulance resource is on its way. Their role is to help stabilise the patient and, in doing so, keep the patient alive until the arrival of the more highly skilled ambulance crew, who are trained to undertake further life saving techniques.
>
> "On the night of the man's death the emergency call was received at 8.59pm and categorised as an R1 which requires that CPR is commenced and a defibrillator is at the scene within eight minutes. The emergency call from the prison confirmed there was a defibrillator

at the scene and cardio pulmonary resuscitation was in progress. The first responder was dispatched at 8.59pm and arrived at the man's cell at approximately 9.28pm. He instructed the officers to continue with the chest compressions whilst he undertook an assessment of cardiac and respiratory outputs. Both were absent.

"A double staffed ambulance was dispatched at 9.01pm and arrived on the scene at 9.44pm. An East of England ambulance service clinical operations manager, a senior paramedic also attended this call dispatched at 9.23pm and arriving on scene at 9.49pm. Advanced life support measures were carried but approximately one hour after the man was found he was declared dead by the attending paramedics.

"It is noted that on the day the man died the road conditions were bad due to snow fall and therefore the twenty nine minute response time for the second vehicle was not met …"

82. The clinical reviewer makes no recommendations on the response or treatment provided by prison staff to the man on the day of his death. We are also satisfied that prison staff acted promptly and professionally when they discovered the man.

The personal officer scheme

83. The man did not work or engage in other prison activities. Despite being assigned two different areas of work, he chose not to attend and was subsequently dismissed. The man's friends told the investigator that despite encouragement to get involved in the gymnasium or go outside for exercise, he spent the majority of his time in his cell, dressed in pyjama bottoms.

84. The man's personal officer completed a request for a transfer on his behalf as well as the IEP report when the man failed to attend work. The man's personal officer said that he had spoken to him on occasions, but the man 'did not say a lot.' Fellow prisoners and some staff said the man engaged with staff when he had to, he also interacted well with a select group of prisoners.

85. We are concerned that staff, particularly the personal officer, do not appear to have enquired more about the man's well-being, and seem to have accepted his withdrawal from the regime as normal behaviour or just the man being 'lazy.' Someone withdrawing from the daily regime to the extent that he did and wearing pyjama bottoms all day should have warranted further investigation to ensure his welfare. In addition, if such enquiries were made they should have been noted in his record. We make the following recommendation.

The Governor should ensure that all personal officers have regular, quality contact with the prisoners allocated to them and that they record their interactions on P-NOMIS.

Mental health awareness

86. During the investigation, staff were asked about their training and particularly if they benefit from mental health awareness training. Staff said that this was not part of the training schedule at Wayland. However, the investigator was told by Norfolk and Waveney NHS Trust that such training is delivered at other prisons within the Eastern Region.

87. Addiction to drugs or alcohol can often mask underlying mental health problems, which will be more apparent as someone is withdrawing. It is therefore surprising that prison staff at Wayland, particularly those working on the IDTS wing do not benefit from such training. If staff had some awareness of mental health issues, it is possible that they would not have normalised the man's behaviour and sought opinion from a medical professional about his disengagement. The clinical reviewer points out that no one at Wayland had considered the man's mental state and considers that officers would benefit from training in this area. We make the following recommendation:

    The Governor should provide mental health awareness training to all staff at Wayland.

The man's property

88. The man's family were understandably upset to learn that he had given away personal items prior to his death. The family felt that such actions should have been noticed by staff as they may have been a precursor for his actions on the day of the man's death.

89. Prisoners are able to have certain personal items in their possession, and if they chose to do so, sign a disclaimer to indicate they are doing so at their own risk. All prisoners are told on reception that to borrow or lend items is a breach of prison rules. The man would have been allowed additional items in his possession and to wear his own clothes as he had earned this privilege as an 'enhanced' prisoner.

90. The searching at Wayland is intelligence-led and cell searches are only carried out when staff have reason to believe a prisoner may have illicit items. In addition to cell searches, staff complete daily checks on the interior of each cell, but this is not for the purpose of looking at prisoners' personal items. The man did not come to the attention of the security department, so was not subject to such procedures.

91. The man's friends suggested a number of reasons to the investigator as to why he might have given away his clothing. Those who knew him well said they felt that he did so freely, without coercion, and the investigation has found no evidence to suggest otherwise. It is reasonable to conclude that the man would have known that selling or lending his property would be against prison rules, and therefore he is not likely to have done so in view of wing staff. However, as previously mentioned, more interaction from prison staff and questioning on

why he had withdrawn from the regime might have enabled staff to identify this trend.

92. Following the man's death, the prison took action to retrieve the items of clothing that were missing. With the help of prisoners on D wing who had known the man, the majority of his property was recovered and returned to his family.

CONCLUSION

93. The man had very little contact with the healthcare departments at Bedford and Wayland. His contact with the mental health services at Bedford was brief and he was discharged after two consultations. Prison staff raised no significant concerns about his mental health at either prison and it seems that, in spite of his withdrawal from prison activities, no one questioned his mental state.

94. The man was unhappy at being recalled to prison and concerned to be facing another lengthy period of custody. His friends at Wayland also thought he had personal problems. The man had been employed at Bedford but he appears to have withdrawn from the regime at Wayland and refused to work. Although staff gave him warnings for not working, there is little evidence that they attempted to seek a reason for his unwillingness to work or to ensure that he was coping.

95. We conclude that the man's death could not have been foreseen. However, there is concern that staff did not question further his reasons for disengaging with the daily regime. The personal officer scheme aims to provide prisoners with a point of contact, with whom they can raise concerns or seek advice. If this had been operated effectively at Wayland, staff might have been more aware of any concerns and been able to offer the man support.

RECOMMENDATIONS

1. The Governor should ensure that all personal officers have regular, quality contact with the prisoners allocated to them and that they record their interactions on P-NOMIS.

   HMP Wayland accepted this recommendation and said:

   Residential managers and staff will be written to regarding the need to maintain regular contact with their prisoner cases. The need to explore and record underlying behaviours or non-engagement with the regime will also be highlighted.

   Residential Managers will monitor this as part of their quality checks.

   A target date for this to be actioned is September 2012

2. The Governor should provide mental health awareness training to all staff at Wayland.

   HMP Wayland accepted this recommendation and said:

   The Mental Health training package, which is currently delivered by the 'Partnerships in Care' organisation as part of the NHS contract has delivered one element of the programme to 33 priority staff members. Monthly training dates have been agreed up until February 2013.

   This two part modular programme is currently under review and will soon consist of four modules. Staff will need to be competent in all four modules before being certified as complete by PICS.

   Wayland will be liaising with other Norfolk prisons to maximise the potential of sharing this training resource.

   Monthly feedback with regards to Mental Health training is received via the Operational Healthcare Meeting.

   A review regarding the progress of this training will take place in March 2013.