The death in custody of a male prisoner

at HM Prison Dorchester on 14 June 2005

Report by the Prisons and Probation Ombudsman for England and Wales

December 2005

This is the report of an investigation into the death of a prisoner at HM Prison Dorchester on 14 June 2005. The prisoner was found hanging in his cell at 1:35pm that day. He had been in custody for only five days. A suicide note addressed to his partner was found in his cell. The prisoner died three days before his 65th birthday.

A post mortem examination conducted on 16 June concluded that the prisoner's death was caused by hanging.

The investigation was carried out by my colleague.

I also commissioned an independent clinical review of the management of the prisoner's health needs while he was at Dorchester. This was carried out by a representative of the South West Dorset Primary Care Trust. I am grateful to him for his report.

My thanks also go to the Governor and staff at Dorchester for their help and co-operation during the investigation.

During the brief time that he was in custody, the prisoner gave no indication that he was contemplating taking his own life. The investigation has found that little could have been done by staff to prevent his death. After the prisoner was found hanging in his cell, prison staff and paramedics made determined and sustained efforts to revive him. Their efforts are worthy of praise.

This published version of the report does not contain any of the original annexes.

Stephen Shaw CBE **December 2005**
Prisons and Probation Ombudsman

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1. Summary

On 5 December 2003, the prisoner appeared at West Sussex Magistrates' Court at Worthing charged with a number of offences that had been committed between 1970 and 1985. The prisoner was committed on bail to appear at Dorchester Crown Court when required. On 10 June 2005, he was convicted of those offences and was remanded in custody at Dorchester to await a pre-sentence report.

The prisoner showed no signs that he was depressed or contemplating suicide, either at court, or during his journey from court to the prison. Upon his arrival at Dorchester, he asked to be treated as a vulnerable prisoner because of the nature of his offences. This request was granted. Ordinarily, he would have been accommodated straightaway in the vulnerable prisoner unit in D Wing, but as there were no vacancies there, the prisoner was located in a single cell in the first-night centre in C Wing. During the next few days, he did not behave in a manner that suggested he might have been depressed or contemplating suicide. Staff had no concerns about him. The locum doctor who saw him the day after his reception did not record details of the assessment he made of the prisoner's mental state.

At about 1:35pm on 14 June, the prisoner was found by a member of staff hanging from the window bars of the same cell in C Wing to which he had originally been allocated. Attempts to revive him were unsuccessful. He was pronounced dead at the scene at 2:15pm by a prison doctor.

The investigation found that staff at Dorchester had no indication that the prisoner might have been feeling suicidal. Prison and paramedic staff made determined and sustained attempts to revive him but sadly those attempts were unsuccessful.

I make recommendations regarding:

- medical record keeping.
- improving systems for raising the alarm in a life-threatening situation
- taking statements from staff
- training staff in the use of emergency first aid equipment
- creating a discrete area in which to isolate the body of a deceased prisoner
- use of radios
- availability of safer cells in the first-night centre

2. Investigation methodology

The investigation was opened on Friday 17 June 2005, when my colleague met with the Governor, the chairman of the Independent Monitoring Board (IMB), the chairman of the local branch of the Prison Officers' Association and the establishment's investigation liaison officer. They were briefed on the nature and scope of the investigation. On the same day, notices were issued to staff and to prisoners announcing the investigation and inviting anyone who wished to contribute to the investigation to make themselves known to my investigator. No-one came forward.

Thirteen members of staff and one prisoner were interviewed.

An independent clinical review of the management of the prisoner's health needs while he was in custody was undertaken by a representative of the South West Dorset Primary Care Trust (PCT).

One of my family liaison officers spoke to the prisoner's partner by telephone to ask her if she wished to raise any concerns relating to the prisoner's death. She confirmed that she did not feel any need to meet my investigator but she was concerned that the prisoner had not been placed on a suicide watch.

3. The deceased

The prisoner was born in 1940. Little is known of his personal and family background. During the six years preceding his imprisonment, the prisoner had been living with his partner.

It is known that the prisoner had accumulated numerous previous convictions and that, in 1978, he was released from Wormwood Scrubs prison after serving a 10 year sentence.

The prisoner was unemployed. He was partially sighted and had suffered from glaucoma. He had no psychiatric history and we have uncovered no evidence that he had ever tried to harm himself.

He died three days before his 65th birthday.

4. HM Prison Dorchester

Dorchester is a small Victorian local prison serving Crown and Magistrates' Courts in Dorset and South Somerset. It is located in the centre of the town. Although the prison is designed to hold no more than 143 adult and young male prisoners, it normally holds nearly double that number.

Prisoners are held in four wings, three of which radiate off a central hub. A and B Wings hold remand and sentenced prisoners. C Wing operates as a first-night centre and D Wing provides accommodation for those segregated for the good order of the prison and for vulnerable prisoners.

Healthcare at Dorchester has, since 1 April 2004, been provided by the South West Dorset Primary Care Trust which works closely with the Dorset and Somerset Prison Partnership. The healthcare centre provides 24-hour medical and nursing cover, with inpatient facilities for up to ten prisoners.

Dorchester was last inspected by Her Majesty's Chief Inspector of Prisons in April 2004. The report of that inspection included a number of observations and recommendations about safer custody and healthcare. None are relevant to this investigation.

The last death in custody at Dorchester was that of a prisoner who was found hanging in his cell on 2 February 2003. He died in hospital on 13 March 2003. The report of the investigation into his death contained three recommendations. None are relevant in this case.

5. Events prior to the prisoner's death

On Friday 10 June 2005, the prisoner was convicted at Dorchester Crown Court of a number of offences he had committed between 1970 and 1985. He was remanded in custody at Dorchester to await a pre-sentence report. He was to return to court for sentencing on 1 July.

The prisoner left the court for Dorchester prison at 3:00pm that day. He was escorted by Reliance Custody Services. He arrived at Dorchester ten minutes later. The Prisoner Escort Record (PER) showed that, although the prisoner was considered to be vulnerable because of the nature of his offences, he was not at risk of suicide or self-harm.

Upon his arrival at Dorchester, the prisoner underwent a first reception health screen. During this interview, he disclosed to a healthcare officer that he had recently consulted a doctor about his eyes, had undergone an operation to remove two cataracts, and had suffered from glaucoma and shoulder pain. He said that, before he was imprisoned, his GP had prescribed eyedrops, Ibuprofen, and Lormetazepam, a benzodiazapine drug that is normally prescribed on a short-term basis for the treatment of anxiety. The health screen form does not make clear whether the prisoner was still taking any of this medication when he arrived at Dorchester. He was also concerned that he experienced skin rashes. He said that he did not drink alcohol or use drugs, that he had no psychiatric history or mental health problems and had never tried to harm himself. In answer to the question, "For some people, coming into prison can be difficult, and a few find it so hard that they may consider harming themselves. Do you feel like that?" he replied that he did not.

During the cell share risk assessment that was conducted as part of the reception procedures, the prisoner said that he had no concerns about sharing a cell with another prisoner. He also said that he was not a person who quickly became angry or frustrated. The member of staff who completed the assessment form noted that there was no evidence of any risks associated with cell-sharing and that there were no concerns about his risk of self-harm.

During the reception procedures, the prisoner asked to be treated as a vulnerable prisoner because of the nature of his offences. His request was immediately granted. Ordinarily, he would have been allocated to the vulnerable prisoner unit in D Wing, but, as there were no vacancies there, he was located in the first-night centre in C Wing. He was placed in a single cell.

Later that day, the prisoner signed a compact that committed the establishment to the provision of an orderly, purposeful and caring regime, and that committed himself to behaving in a responsible manner and to taking part in the regime offered. He also signed an induction sheet to show that he had been briefed on the establishment's policy for anti-bullying, race relations, incentives and earned privileges, drug abuse, visits and unit regime. During

his induction interview, it was noted that the prisoner showed no signs that suggested that he might have been at risk of self-harm.

At about midday on Saturday 11 June, the prisoner was seen by a locum doctor who made brief notes on a proforma that recorded the prisoner's general health. Although he did not make an in-depth mental health assessment, the doctor was able to gauge that there was nothing in the prisoner's demeanour to give him cause for concern. He told my investigator that he thought that the prisoner "looked a bit down". The doctor was not surprised at this, given the fact that the prisoner had only been imprisoned the previous day. The doctor did not make any record of his assessment of the prisoner's mental state.

On the same day, the prisoner was interviewed as part of the induction process. It was noted that he had asked to be kept apart from other prisoners because of the nature of his offences, and because he was a poor coper. The prisoner's designation as a vulnerable prisoner was therefore formally authorised. He then signed a further compact specific to the regime offered to vulnerable prisoners. The prisoner was seen during the day by a member of the Chaplaincy team as part of the induction programme. The Chaplain had no concerns about the prisoner.

During the weekend, the prisoner spent each day in D Wing mixing with other vulnerable prisoners. He took exercise, associated freely and took all his meals. The officers on duty in C and D Wings saw nothing in the prisoner's demeanour that suggested that he might have been depressed, preoccupied or contemplating suicide.

The prisoner made three telephone calls to his partner over the weekend. In the first call, he referred to a suggestion made to him at court that the offences of which he had been convicted were such that he was he likely to be given a long prison sentence. However, at no stage during this or his other telephone conversations did he allude to any idea or plan to end his life.

On Monday 13 June, the prisoner underwent a needs assessment interview by a member of Dorchester's resettlement team. He explained that he had no difficulties with reading, writing and numeracy, and had no disability other than partial sight. He said that he required no assistance with regard to housing or employment or in relation to the abuse of drugs or alcohol. Later that day, the prisoner was seen by another member of the Chaplaincy team. This Chaplain had no concerns about him.

On Tuesday 14 June, the prisoner spent the morning in D Wing, on exercise and association with other vulnerable prisoners. The Governor had arranged a staff meeting for midday. Lunch was therefore served to prisoners at 11:40am, a little earlier than usual. The prisoner took his meal from the servery in D Wing and made his way back to his cell in C Wing. At about 11:45am he asked an officer if it would be possible for him to attend an education class in D Wing that afternoon. The officer promised the prisoner that he would check to see whether there was a class and that, if so, he would

arrange for him to attend. The officer then locked the prisoner in his cell and left for the staff meeting. The unit was not patrolled during the meeting or the lunch break. That same officer was the last person to see the prisoner alive.

At 1:00pm, another officer commenced his duty as relief reception officer and was then deployed to C Wing at about 1:30pm. He started to collect used meal trays from each cell with the help of the wing cleaner. Shortly after 1:30pm, that officer unlocked the door of the cell in which the prisoner was located and discovered him hanging from the window bars. The prisoner was suspended by a ligature made from a length of torn bedsheet attached to the hinge of the window. He was facing towards the cell door. His feet were clear of the floor. There were no signs of life.

6. Events following the discovery of the prisoner

The officer, who was not equipped with a radio, ran to the wing office where he telephoned the Orderly Officer to ask for assistance, leaving the prisoner's cell door open. The wing cleaner followed him to the office. The officer then returned the wing cleaner to his cell and opened the gate leading into the wing so that staff could enter the wing more quickly. He was absent from the scene of the incident for approximately 30 seconds while he summoned help. Meanwhile, on receipt of his call, the Orderly Officer directed a number of staff who were near his office to go to his assistance. A number of discipline and healthcare staff arrived about 15 seconds later. Between them, they removed the ligature from the window and from the prisoner's neck. They all described the prisoner as being cyanosed and showing no signs of life.

The investigation found that the local contingency plans do not contain any reference to the procedures to be followed for calling the emergency services. However, among those who responded to the incident was the manager in charge of B Wing. When he arrived, he used his radio to alert the communications room to the need to call an ambulance. As there are no facilities in the communications room for dialling 999, the communications officer shouted through to the gatekeeper who pressed a button on a dedicated telephone set that connects directly with the 999 facility. The incident log shows that this was done at 1:35pm.

Meanwhile, more healthcare staff arrived at the prisoner's cell. They helped carry the prisoner out of the cell to the landing where he was laid on the floor. The ligature was removed from the prisoner's neck and staff checked for signs of life. It was noted that the prisoner was pale and cyanosed with bruising to his throat and neck. His tongue was enlarged and protruding. An airway was inserted and oxygen was administered through an ambubag. Staff maintained the prisoner's airway by tilting his head and holding the mask on his face. The defibrillator available in the healthcare centre was not taken to the prisoner as no staff trained in its use were on duty. Cardio-pulmonary resuscitation (CPR) techniques were applied until approximately 1:45pm when a paramedic arrived.

The paramedic applied a defibrillator which advised not to shock the patient. CPR was therefore recommenced. A canula was inserted into the prisoner's forearm. Between 1:51pm and 1:54pm, adrenalin and atropine were administered with no effect. CPR techniques were continued until 1:56pm when all attempts to revive the prisoner were terminated. A prison doctor pronounced death at 2:15pm.

The police and Coroner's office were informed of the prisoner's death. The establishment's Police Liaison Officer attended. Scenes of crime officers searched the prisoner's cell and took possession of a letter he had written to his partner that day. This was treated as a suicide note. The police took photographs of the cell and of the prisoner's body. These procedures took approximately two hours to complete. At 4:13pm, the duty undertakers were asked to remove the body. They left the prison at about 5:30pm. By this time,

the prisoner had been lying dead on the landing in C Wing for over three hours. His body was covered with a blanket. During this period, the prisoners in C Wing were kept locked in their cells, and the incident log-keeper stayed by the body.

Subsequently, the Senior Lead Nurse for the Dorset and Somerset Partnership gave managerial counselling and support to the healthcare staff. The Governor chaired a debrief of all staff involved. All those staff who were interviewed said that they were given appropriate care and support by the Governor and the establishment's care team.

The prisoner's partner was informed of his death by a member of the Chaplaincy team from a prison located not far from where she lived.

The prisoner's partner and her son-in-law visited Dorchester on Wednesday 15 June. They met the Governor and the Chaplain, who showed them the prisoner's cell and spent time with them in private. The Governor wrote to the prisoner's partner the following day to offer her his condolences and practical support. The Police Liaison Officer gave her a copy of the letter the prisoner had left for her. In it, the prisoner wrote that he did not expect to leave prison and that he could not face a life without his partner.

7. Consideration of issues arising from the investigation

The following issues arose during the investigation:

- **Attempts to revive the prisoner**

I draw special attention to the conduct of the prison staff who found the prisoner hanging, and to those, including the paramedic, who made determined and sustained attempts to revive him. They did so in very harrowing circumstances. The conduct of all those involved is worthy of praise.

- **Should the prisoner have been made subject to self-harm monitoring procedures given the nature of his offences and his age?**

The prisoner's partner was concerned that he was not placed on a suicide watch because of his age and the nature of his offences.

The investigation found that the prisoner asked to be treated as a vulnerable prisoner because of the nature of his offences and that this request was granted immediately. He was therefore located in an area of the prison that afforded him safety from other prisoners. I consider that this was an appropriate means of managing the prisoner's vulnerability from others.

The prisoner was 64 years old when he entered prison on 10 June. He had not been in prison since 1978. He had been convicted of a number of offences that were likely to place him in danger from other prisoners. He was expecting a prison sentence that was likely to keep him apart from his partner for a long time. These are indicators of a potential risk of self-harm or suicide. However, the judgement as to whether the prisoner should have been made subject to any self-harm monitoring procedures needs to draw a balance between these indicators and the fact that during his time at Dorchester the prisoner did not display any signs that he was contemplating suicide. I therefore believe that staff at Dorchester were reasonable in their judgement that the prisoner did not need to be made subject to self-harm monitoring procedures.

- **Should the prisoner have been allocated a shared cell?**

In ordinary circumstances, the decision to grant the prisoner vulnerable prisoner status would have necessitated his location in D Wing where he could benefit from a full regime with other vulnerable prisoners. However, on 14 June, no spaces were available in that wing. Consequently, the prisoner was allocated a cell in the first-night centre in C Wing. As there were no other vulnerable prisoners located in that wing with whom the prisoner might have been able to share a cell, he was accommodated in a cell on his own. My investigator was told that, had the prisoner been assessed as at risk of self-harm or suicide, he would not have been allocated a single cell.

In view of the fact that the prisoner was not assessed as a suicide risk, I accept that the decision to accommodate him on his own was justified. However, given that prisoners are more at risk in the first few days after their arrival in prison, I am concerned that a further tragedy could occur at Dorchester. In order to reduce such a risk, the Governor, with the support of the Area Manager and Safer Custody Group in Prison Service Headquarters, should arrange for the conversion of an appropriate number of cells in the first -night centre into safer (ligature-free) cells as a matter of urgency. These cells could be used to accommodate those subject to self-harm or suicide monitoring procedures and those accommodated alone.

- **Should the first-night centre be patrolled during meal breaks?**

On 14 June, a full staff meeting took place at midday. The midday meal for prisoners was therefore served earlier than usual. The prisoner was last seen alive at about 11:45am on that day when he was locked in his cell by an officer after collecting his lunch meal. The prisoner was found hanging one and three quarter hours later. The first-night centre in C Wing was not patrolled during that period. During meal breaks at Dorchester, unless there are prisoners subject to self-harm monitoring procedures, patrol staff remain in the vicinity of the centre office where they are able to monitor the cell-call display board and make regular visits to those assessed as at risk of self-harm. They can be deployed quickly from the centre to any alarm raised in the residential area.

The option of ensuring that all units are permanently patrolled by day and by night in any establishment would have very significant resource implications. I therefore do not criticise the fact that the first-night centre was not patrolled during the lunch break on 14 June. That said, the Governor should continue to be mindful of the heightened risk of suicide presented generally by prisoners during their first days and weeks in prison.

- **Initial assessment of the prisoner's mental health**

The locum doctor who saw the prisoner the day after he arrived at Dorchester checked his physical health but did not record any details of the assessment he made of the prisoner's mental state. The doctor was able to gauge that there was nothing in the prisoner's demeanour to give him cause for concern, although he thought that he "looked a bit down". The Governor, in conjunction with the PCT, should ensure that all doctors are aware of the need to make a proper record of their assessment of the current mental state of all newly received prisoners, particularly in relation to their risk of self-harm.

- **Raising the alarm and arrangements for calling an ambulance**

The officer who found the prisoner hanging was not equipped with a radio. He therefore had to leave the cell for about 30 seconds to telephone for assistance from the C Wing office. Officers on duty on their own in the first-night centre ought to be equipped with a radio.

The investigation found that there is no facility in the communications room at Dorchester for the communications officer to dial 999. Whenever the communications officers receive an emergency call over the internal radio network, they have to ask the gatekeeper in an adjacent area of the gatelodge to call for an ambulance. It is not necessary for gatekeepers to dial the emergency number. Instead they merely press a button on a dedicated telephone set to be connected to the emergency services. This process takes no more than a second or two to complete. After the prisoner had been found hanging, a Senior Officer used his radio to alert the communications officer to the need to call an ambulance. No delay was incurred. The fact that the communications officer has to rely on the gatekeeper to call the emergency services was not, therefore, a critical issue in this case.

Local contingency plans do not contain any guidance to staff about the procedures to be followed for raising the alarm or for calling an ambulance in the event of a life-threatening situation. This was not a significant factor in the circumstances described here, but it might be in the future. Local contingency plans should set out clear instructions to staff about the procedures for raising the alarm in a life-threatening situation and for calling the emergency services.

- **Statements from staff**

Not all those staff who were involved in responding to the discovery of the prisoner submitted statements to the Governor. Most of those staff who were interviewed seemed to be unaware of any requirement to do so. Statements should be written as soon as possible after an incident and should describe the role undertaken by each member of staff. The Governor should clarify local policy in this area of incident management and should make his policy clear in the local contingency plans.

- **Emergency equipment**

A defibrillator is available in the healthcare centre. At the time of the investigation, only three members of the healthcare team were trained in its use. Of those, none were on duty on 14 June. There is no evidence to show that the fact that the prison's defibrillator was not used in the initial first aid applied to the prisoner was a critical factor. The investigation has found that there are plans for further staff to be trained in the use of the defibrillator in due course. These should be implemented without delay.

- **Removal of the prisoner's body from the prison**

The prisoner's body remained on the landing outside his cell in C Wing covered by a blanket for about three hours after he was pronounced dead. The delay in removing his body to the mortuary caused considerable distress to the members of staff who had to remain in the wing, and to the prisoners who remained locked in their cells throughout. The investigation found that the police could not have carried out their forensic tasks more efficiently or more speedily. The Governor and his staff were unable, in the circumstances, to arrange the removal of the prisoner's body, or to establish a discrete area in

which to isolate his body. However, contingency plans for the management of any future death in custody should include the acquisition and use of a screen similar to that used by the police at the scene of a crime.

8. Recommendations

- The Governor, in conjunction with the PCT, should ensure that all doctors are aware of the need to make a proper record of their assessment of the current mental state of all newly received prisoners, particularly in relation to their risk of self-harm.

- The Governor should review the local contingency plans to ensure that there are clear instructions to staff for

  -raising the alarm in a life-threatening situation.
  -calling the emergency services.
  -taking statements from staff after a serious incident.
  -the acquisition and use of a screen similar to that used by the police at the scene of a crime.

- The investigation found there are plans for further staff to be trained in the use of a defibrillator. The Governor should ensure that this training is implemented without delay.

- The Governor should ensure that all staff patrolling wings are equipped with a radio.

- In order to reduce the risk of a further death in the first-night centre, the Governor, with the support of the Area Manager and Safer Custody Group in Prison Service Headquarters, should arrange for the conversion of an appropriate number of cells in the first-night centre into safer (ligature-free) cells as a matter of urgency.

At consultation stage, the Governor asked for the following text to be inserted:

I have accepted all the recommendations and have taken/will take the following actions:

- I will work with the PCT to ensure that doctors properly record their assessment of the current mental state and risk of self harm of all newly received prisoners.

- We will also provide defibrillator training where it is required.

- Contingency plans have already been reviewed and amended to provide clear instructions to staff about:

  - raising the alarm in a life threatening situation
  - calling the emergency services
  - taking statements from staff after a serious incident

- We have ordered a tent to protect and screen similar incidents in future.

- I have issued a Governor's Order stating that all patrol staff must carry a radio.

- I will submit immediately a business case to the new Area Manager to fund the provision of safer cells for the first night centre.