Investigation into the circumstances surrounding the death of a man at HMP Everthorpe in October 2006

Report by the Prisons and Probation Ombudsman for England and Wales

August 2007

This is the report of an investigation into the death of a man at HMP Everthorpe in October 2006. He was discovered hanging in his cell, suspended by a bed sheet tied to a light fitting. His death has been investigated by Humberside Police who are satisfied that no one else was involved.

I offer my sincere condolences to the man's family and friends for their loss. I hope that this report answers their questions, but recognise that it may not alleviate their distress or lessen their grief. They describe him as a cheerful and happy person despite his incarceration.

The man was born in 1984, and was 22 when he died. He had been in prison on this occasion since May 2004. In June 2002, he had received a custodial sentence for two violent offences. He was released on licence in March 2004, and was supervised by the Probation Service. However, in May 2004, the man was arrested by the police for his alleged involvement in another violent offence. Due to the serious nature of the allegation, the Home Office revoked his licence and recalled him to prison to serve the outstanding part of his custodial sentence. The court dealing with the new offence also remanded him into custody.

In March 2005, the man appeared at Sheffield Crown Court and received a sentence of five years and six months' imprisonment. He was initially held at HMP Doncaster. He was transferred to Everthorpe on 1 September 2005, and remained there until his death 13 months later. The man was a popular prisoner amongst his peers and staff.

I would like to express my thanks to the Governor of Everthorpe, his staff, the chaplaincy, and the Independent Monitoring Board (IMB), for their help and active cooperation throughout my investigation. I am grateful too to, East Riding of Yorkshire PCT, for her assistance. I also wish to thank Humberside Police who have willingly shared their information. In conducting this investigation, I have also been assisted by the findings from a report by HM Chief Inspector of Prisons, following the unannounced Inspection of Everthorpe on 25 and 26 April 2006.

The death of the man was the first apparently self inflicted death to have occurred at Everthorpe since I took responsibility for the investigation of all deaths in prison in April 2004. In the man's case, he had shared with no one (either staff or prisoner) anything that might have indicated that he was at risk of suicide or self-harm. His mother does not believe he intended to take his own life. However, some possible indications of self-harm were not picked up by the prison, and a record that he had cut his wrist on a previous sentence seems to have been missed.

The Governor will wish to consider a number of important issues that have emerged from this investigation. The possible abuse of subutex (a growing problem in many prisons) is one of them. Indeed, my report contains a number of criticisms and makes ten recommendations. That said, and in sad circumstances, this is a report that also contains much that reflects well upon Everthorpe and the Prison Service as a whole.

Stephen Shaw CBE
Prisons and Probation Ombudsman **August 2007**

SUMMARY

The man was found hanging in his single cell at Everthorpe at around midnight on 21/22 October 2006. He was 22 years old and had been at Everthorpe since 1 September 2005.

In March 2005, the man had appeared at Sheffield Crown Court and received a sentence of five years and six months' imprisonment. It was not his first time in custody, and he had told staff at HMP Doncaster that on a previous sentence he had self-harmed by cutting his wrist.

Following his sentencing in March 2005, the man was initially held at HMP Doncaster. On 1 August 2005, he was told that his father had died of a heart attack. the man was taken to healthcare who documented that he was very shaken and in shock. The man denied feeling suicidal or wanting to harm himself.

He was transferred to Everthorpe on 1 September 2005, and remained there until his death 13 months later. The man was a popular prisoner amongst his peers and staff and gave absolutely no indication that he might have been at risk. It is known that the man was unhappy about the terms of his late father's will, but this was not seen as a possible cause of self-harm.

The fact that the man was unwilling to be treated for a number of injuries was also not identified as a possible indicator of self-harm.

On Saturday 21 October 2006, the man apparently seemed his normal self, if a little more subdued and quiet than usual. His close friends put this down to the fact that they had received visits and the man had not. At around midnight, an Operational Support Grade (OSG) officer went to the man's cell to ask him to turn his music down as it was playing unusually loudly. On looking through the cell flap, he saw the man with a green t-shirt over his head and suspended by a bed sheet attached to the light fitting. The OSG summoned assistance on his radio, entered the cell and cut the man down. Staff tried for some time to resuscitate the man but to no avail. A doctor arrived at 00:25am on Sunday 22 October and pronounced that the man had died.

The man's mother has no concerns about the man's treatment whilst at Everthorpe. She is full of praise for the staff and prisoners whom she met at the prison. She does not believe that the man intended to take his life.

I also have nothing but praise for the response of staff after the man was found hanging. They acted promptly and professionally and I am satisfied that everything possible was done to try and save the man's life. Systems for allowing the doctor and ambulance access to the prison worked well.

I also commend staff and prisoners for the way they have assisted the man's mother. The man's mother was particularly grateful for the sensitive way the Governor, his staff and prisoners have engaged with her since her son's death. She was especially touched by the kindness shown by all at one of two services conducted in the man's memory.

The staff/prisoner interaction at Everthorpe was some of the best that my investigators have witnessed. Perhaps for that reason, the death of the man had affected everyone that my investigators met. The local branch of the Prison Officers' Association, the chaplaincy, and many staff and prisoners have asked for their condolences to be passed on to the man's mother.

THE INVESTIGATION PROCESS

1. This investigation was formally opened at Everthorpe on 25 October 2006 by investigators from my office, three days after the man's death. The Governor and his staff produced the man's core record and a number of other documents for examination. Notices were issued to staff and prisoners telling them of the investigation and inviting anyone with relevant information to make themselves' known to the investigation team. My investigators were given unrestricted access to the prison and its staff, and to all documentation relating to the man. My investigators spoke to a member of the Independent Monitoring Board (IMB) and the chaplaincy. They also spoke to Humberside Police in relation to issues of common interest. My investigators were given a tour of the prison and wing where the man died, and spoke to prisoners who knew him well.

2. My investigators also obtained the man's clinical records, and a copy was sent to East Yorkshire Primary Care Trust so that an independent review of the care he received in Everthorpe could be undertaken. The review was completed by, East Riding of Yorkshire PCT.

3. Tape recorded interviews were conducted with prisoners and staff who had significant contact with the man, and transcripts of these are included as annexes to this report. All those interviewed have been asked to sign the transcript and indicate any corrections.

4. My investigators have also had access to the reports of inspections conducted by Her Majesty's Chief Inspector of Prisons.

5. My Investigator, and Family Liaison Officer from my office, met the man's mother, and outlined the details of the investigation to date.

6. The man's mother said that her son telephoned her most weeks, and she described the conversations in the latter months as akin to talking to a supportive friend. She described a change that took place following the man's father's death, and the mugging of a close friend. He started to look back on his life and not to like things from his past. He became more thoughtful and his behaviour changed for the better. For example, he would phone her to thank her for sending him money. The man's mother said at first his plans for his future were unrealistic and unlikely, but more lately they had become more and more realistic. He was hopeful about his future, which is why her son's death had come as such a shock to her. The man's mother is sure that her son did not mean to take his life.

7. The man's mother has three theories about why the man ended his life, none of which was intentional. These are:

    - he may have been acting out something he had seen on the internet to get a buzz and it went wrong (although as he had no access to the internet he may have heard this from someone);

- he wrote rap music and he may have been acting out the lyrics to be able to write about the experience more vividly – she wondered if he was writing lyrics about suicide – the Police have taken a folder with his rap music lyrics in;

- he had taken some mind altering drugs.

8. The man's mother said that her son was not depressed. She is aware that he was found with a t-shirt over his head. Her son did not like physical pain and she does not think he would inflict this on himself.

9. The man's mother has been impressed with the caring and respectful atmosphere at the prison. She visited and attended a memorial service for the man, and was able to meet staff and prisoners. The Governor gave the man's mother his mobile telephone number for her to contact him if she wanted.

HMP EVERTHORPE

10. Everthorpe is a category C training prison which first opened in 1958 as a borstal. It was converted to its present role in 1991 and now holds convicted adult male prisoners. In 2005, Everthorpe underwent a significant expansion programme that provided two new wings and 220 new prison places. It now has six wings and an operational capacity of 689 prisoners.

11. Her Majesty's Chief Inspector of Prisons conducted an unannounced inspection at Everthorpe on 25 and 26 April 2006. She concluded that Everthorpe provided a safe environment for prisoners, and one that was responsive to the individual needs of those identified as being at risk of self-harm and suicide.

12. As Prisons and Probation Ombudsman, I assumed responsibility for investigating deaths in prisons in April 2004. the man is the only prisoner to have died at Everthorpe since I took on this role.

13. My investigators found that the staff/ prisoner interaction at Everthorpe was extremely positive, with staff having a good knowledge of prisoners as individuals.

14. In common with other prisons, Everthorpe runs a personal officer scheme. Prisoners are allocated two officers on their wing to act as a first point of contact in all matters. My investigators found that the personal officer scheme at Everthorpe was well run, with officers having a good knowledge of those prisoners in their charge.

15. The healthcare facilities at Everthorpe are linked to the East Riding of Yorkshire Primary Care Trust (PCT). (On October 1 2006, the East Riding of Yorkshire PCT was formed from a merger of the Yorkshire Wolds & Coast PCT and the East Yorkshire PCT.) Everthorpe does not run a 24-hour healthcare facility. Outside normal healthcare hours, arrangements are made for local doctors to attend if needed or in emergencies ambulances are summoned.

16. Each officer and operational support grade (OSG) performing night duty is issued with a sealed key pouch to be opened only in emergencies and a fish knife (a specially designed knife shaped like a fish) to assist in cutting ligatures. OSGs would normally have little direct contact with prisoners.

KEY FINDINGS

17. In June 2002, the man received a custodial sentence for two violent offences. He was released on licence in March 2004 and was supervised by the Probation Service. In May 2004, the man was arrested by the police for his alleged involvement in another violent offence. Due to the serious nature of the allegation against him, the Home Office revoked his licence and recalled him to prison to serve the outstanding part of his sentence. The court dealing with the new offence also remanded him into custody.

18. The man was remanded in May 2004 to HMP Doncaster, where he completed a healthcare questionnaire and eczema was noted as a current health problem. The man's recent drug use was documented as heroin and crack cocaine, although the man's mother informs us that this was not true and was made up by her son, possibly to get on the detoxification programme. He was offered detoxification, and creams for his eczema were prescribed. The man showed no signs of mental illness or clinical depression, and no ideas of self harm/suicide were recorded.

19. On 27 November 2004, a further remand health questionnaire was completed. He said that he had used cannabis two days earlier, but he showed no signs of mental illness, clinical depression or ideas of self-harm. In respect of the man's previous history of self harm, it was noted that he had cut his wrist five years earlier, and had been on a self harm watch. The man's mother pointed out to my investigators that, had the man cut his wrists five years earlier, she would have been informed. As she was not she believes the information recorded on the questionnaire is incorrect. She added that she thought the only time her son was on a watch for self-harm was when he was held in police custody prior to his first time in prison.

20. In March 2005, the man appeared at Sheffield Crown Court and received a sentence of five years and six months imprisonment. The length of sentence took into account the fact that he was on licence from prison when he committed the offence in May 2004, and for which he received an additional 150 days. Following his sentence, a Mental Health Questionnaire was carried out when he got back to Doncaster. No mental health issues were identified.

21. On 1 August, the man was told that his father had died of a heart attack that morning. He was taken to healthcare, where it was documented that the man was very shaken and in shock. He denied feeling suicidal or wanting to harm himself. The man was prescribed a sleeping pill for three consecutive nights. On 10 August, he was given a 14 day course of sleeping pills to help him sleep.

22. On 1 September 2005, as part of his sentence planning, the man was transferred to Everthorpe where a healthcare reception questionnaire was completed. The questionnaire identified that the man had a history of drug misuse (cannabis) and it was recorded that he drank 40 units of alcohol a week. The man's mother told my investigators that she thought her son exaggerated the amount of alcohol he consumed to the person carrying out

the assessment. Mental health problems and self harm suicide sections of the questionnaire were not completed. The man asked to see the Medical Officer (MO) for a review of his medication.

23. On 8 September 2005, the man was seen by the MO who prescribed cream for eczema, and noted his recent bereavement. On 20 January 2006, the man was prescribed dicolfenac for dental pain. On 17 March, he was seen on the wing by the MO. The man was not well, with possible flu symptoms documented. He was prescribed antibiotics and paracetamol, and seen regularly by healthcare over a four day period until his condition improved.

24. On 17 April 2006, a security information report was submitted that indicated that the man appeared to be under the influence of alcohol. On 26 April, he was seen on the wing by healthcare and said he had fainted the previous day. His blood pressure was within the normal range, and two scratches and bruising were noted behind his left ear. The man said he had been lying on his bed and got up quickly. He was seen the following day by the MO who noted a small bruise behind his ear.

25. On 3 July, prison intelligence suggested that the man and another prisoner were bringing in drugs (subutex – a medication used as a heroin substitute) from visits. On 27 July, the man was seen with a cut to his hand but he was unwilling for healthcare to look at it. On 30 August, he was seen by healthcare with acne on his chest and back and was prescribed erythromycin cream.

26. One of two personal officers that the man could go to if he had any problems. recalled starting work on the wing in July when the man was an enhanced prisoner with wing cleaner duties, and that he had problems getting out of bed in the morning. The officer gave him two written warnings for his behaviour. The first was on 6 September when he was not behind his door for evening lock up. The second was a week later on 13 September when he was not ready in time to go to the workshop.

27. The other of the man's personal officers, said that the man did not want to talk to staff very often. He had a lot of close friends on the wing and he described him as a bit of a 'jack the lad'. The man found it difficult to get up in the morning, and when he was out of his cell he was one of the last to return. A security information report was submitted in September recorded that the man was found to be playing poker during his time in a workshop.

28. A prisoner at Everthorpe knew the man from Sheffield. He met him again at Everthorpe whilst serving a sentence, and was aware that the man's father had died. He described the man as a larger than life character, always laughing and smiling, a decent lad, and a pleasure to know. The prisoner said that, although they were on different wings, they had worked together in a computer aided design workshop for several weeks.

29. On the morning of Friday 20 October, the man recalls being in the workshop as usual, and the man was sitting with another prisoner. They were laughing

and doing hip hop and 'beatbox'. He described the man as being pretty upbeat and wished everybody attending the class could be as happy as he was. Prisoners and staff liked the man, and he said the man had the utmost respect for everyone. He said that the man did not attend class on the Friday afternoon before he died.

30. A teacher employed at Everthorpe, who teaches computer information and technology said, the man had been in his class of 12 for seven weeks prior to his death. The teacher recalled that, when the man first attended his class, he was quite open about the fact that he was not really interested in computers. He was not a hard working prisoner and, although the teacher tried hard to engage with him, the man was not interested and told him that he would never want a career in computers. However, he was keen to work if the teacher gave him something to type, and his real interests were sport, fitness, and health and diet. The teacher tried to facilitate a relevant course. The man had asked the teacher to help him draft a letter to a solicitor over his concerns over his late father's estate.

31. The teacher described the man as a prisoner who always had a smile on his face, cheerful and one who got on with everybody. On the Friday morning before the man's death, the teacher said that whilst in class the man was laughing and joking as usual. He thought he was the last person to arrive in his class, but that was not unusual**.**

Saturday 21 October 2006

32. Another prisoner at Everthorpe, said during interview that he had met the man for the first time when he arrived at the prison 14 months previously. He said that the man looked out for him and asked him if he wanted anything. The prisoner told my investigators that he knew the man smoked cannabis "now and again" but he did not believe he took anything else. He described the man as kind and said they became good friends. The man had a dream of becoming a famous rapper and was good at card tricks.

33. The prisoner said that the day of the man's death was just a normal day. They got up, had a shower, got dressed and went to each others' cells, drank tea, smoked, listened to music, got bored, played pool, table football, and had fun by winding the staff up and talking rubbish to them. The man made a number of telephone calls during the afternoon.

34. The prisoner had a visit that afternoon and, when he returned, he said that the man looked really down in comparison to how he had been in the morning. The prisoner asked what was wrong, and the man said he had been trying to telephone some of his people but could not get through. The prisoner told him that it was not a big problem and that he should not feel down. He also said that, if the man had problems, he kept them to himself.

35. When all the prisoners were told return to their cells for the evening, the man was in the prisoner's cell. On reflection, the prisoner felt that the man wanted to say something to him that afternoon, but did not. The prisoner told my

investigators that he did not think the man smoked cannabis or took any other illegal drugs.

36. Another prisoner met the man when he first went to Everthorpe, and they used to relax, exercise, play pool and table football together every day. He described the man as bubbly, a 'jack the lad' (a phrase, as noted above, also used by a member of staff), who was liked by everybody. On Saturday 21 October, they were both on the exercise yard as neither had any visitors. The prisoner thought the man looked depressed that afternoon, and asked him what the matter was to which he replied that he was alright.

37. The man's mother was aware that her son had tried to call her at approximately 2.55pm on 21 October, but she was out with her dog. He then called a friend who said that he seemed fine, was talking about the future and about getting out of prison. He had asked for details about an intensive driving course. After this call, he told his prison friends that "all of my friends are moving away". His friends say his mood dipped, but he later seemed okay.

38. A further prisoner at Everthorpe said he had known the man well for four months, having met him in prison. He said the man befriended him as soon as arrived at Everthorpe, and he had a close friendship with him. He said that they all looked out for one another. They played table football every day and were laughing all the time. The man used to smoke cannabis, and that he had previously taken subutex which had been smuggled into the prison. He described the man as a really funny guy, who would make people laugh and kept everything positive. He had the ability to cheer up prisoners, and was always telling them to stop getting stressed.

39. The prisoner recalled that everything was alright in the morning of 21 October, and he played table football with the man. They then went for a shower, and in the afternoon played more table football until he went off for a family visit. When they returned from their visit, the prisoner said that the man looked a bit down so they asked what the matter was. The man replied that nothing was the matter. The prisoner said the man smoked cannabis in his cell, and they had another game of football before going to their respective cells at 5.30pm.

40. A prisoner at Everthorpe, who lived opposite the man on D wing and knew him for six weeks before the man's death, said their relationship was strong, and they were both interested in music and rapping. The prisoner said that the man was also very good at card tricks. They attended the information technology workshop together. The prisoner said the man's mood was fine. He was aware that the man had previously taken illicit subutex.

41. On the evening of 21 October, the man and another prisoner played table tennis. The prisoner who lived opposite the man said that he was the last person to speak to the man before they were locked in their respective cells for the night. The man came into his cell and looked through his CD collection, before an officer arrived to lock the cell. The prisoner lent the man two CDs.

42. An Operational Support Grade (OSG) started his night shift at Everthorpe at 8:20pm on 21 October. He received a briefing about matters of interest from the officer going off duty. He was told that another prisoner was on a self harm watch (i.e. subject to special self-harm support and monitoring), and had to be observed twice during the night.

43. The OSG was responsible for looking after approximately 200 prisoners on C and D wings. He walked around the wings checking all the cell doors were locked and the fabric of the building was intact, and dealt with prisoners who rang their cell bells. At 9:30pm, he commenced pegging (this means that he used an electronic wand to record his movements at predetermined pegging points).

44. The prisoner who lived in the cell next to the man's, said he had known him since his arrival at Everthorpe. They exchanged cigarettes on occasions. The prisoner described the man as a polite and outgoing young lad, who generally had a smile on his face and was always laughing.

45. At about 11.00pm, the prisoner said that he was watching television and heard what he describes as rap music playing loudly from the man's cell. After approximately 15 minutes, he realised that the same track was playing repeatedly and thought that the man was jotting down the words and then rapping. He waited until 11.45am and then banged on their adjoining wall, but still the track kept playing. The prisoner was reluctant to ring his cell bell to draw the noise to the attention of the prison staff, but thought something might be wrong with the man. As he went to ring his cell bell, he heard a member of staff open the man's cell flap and swear. He heard the member of staff use his radio to summon assistance.

46. Just before midnight, the OSG pegged on the third floor landing of C wing. He heard loud music, and made his way to cell C:24 where the music was coming from. The OSG opened the observation panel and saw the man hanging from the light fitting with a ligature made from a bed sheet. A green t-shirt covered the man's head. His feet were not touching the floor, and the cell chair was behind him.

47. The OSG immediately used his radio to inform Oscar 1 (the code designating the Senior Officer in charge of the prison) what he had found and his location. He then broke the seal on his key pouch, went into the cell, removed his ligature knife from its pouch and climbed on the cell bed. The OSG held the man around his body and cut the ligature between the light fitting and the man's neck. As the man fell, the OSG held onto him and placed him on the bed. As he did this, the man's head hit the wall.

48. Although the OSG has had no first aid training, he thought that the man was dead. He turned the music off in the cell. He immediately went back onto the landing and called the Senior Officer and other officers. Officers started resuscitation efforts, giving mouth to mouth resuscitation and chest compressions.

The Governor should consider whether all staff who work with prisoners when the healthcare centre is closed should be qualified to administer first aid.

49. On the night of 21 October, the officer in charge call sign Oscar 1 arrived for work at 8.00pm and ensured that all the prisoners, staff, radios and keys were accounted for. Oscar 1 knew the man well and said that he was quite jovial, had a good sense of humour, and always gave the impression that he would never be the first to work and the last one away. At around midnight, Oscar 1 received an urgent call over the radio network, telling him that there was an attempted suicide on D wing. Oscar 1 immediately went to the wing and arrived with other who had the radio call signs Oscar 2 and Oscar 3 respectively.

50. As they entered the wing, Oscar 1 remembered hearing loud music being played. The OSG, who was on landing two, signalled to them. Oscar 1 cannot remember what the OSG said, but recalled that he looked shocked. Oscar 1 went into cell D2:26 and saw the man lying on the bed with his face covered with what he described as a hood. He was lying face up, and Oscar 1 asked Oscar 2 and 3 to attempt resuscitation.

51. Oscar 1 radioed the control room to ask for an ambulance and doctor, and then left the cell to implement the prison contingency plans and ensure that the doctor and ambulance could enter the establishment as quickly as possible. The control room log records that Oscar 1 requested the ambulance at 00.04am, and the call was made a minute later. The duty manager was informed two minutes later at 00.07am, and the doctor at 00.10am.

52. Oscar 2 started the night shift at Everthorpe at 8.30pm on Saturday 21 October. At around midnight, he heard a radio call saying that there was an attempted suicide on D Wing. He arrived on D wing with Oscar 1 in less then a minute of receiving the call. They were directed to cell D2:26 by the OSG. As they entered the cell, Oscar 2 saw the man lying on the bed. Oscar 1 checked his pulse, but could not find one.

53. Oscar 2 left the cell to collect the resuscitation mask and equipment from the wing office, and then returned to the cell. He removed the green prison t-shirt that was covering the man's face. He began to administer mouth to mouth resuscitation and chest compressions, at a cycle of two breaths and 15 chest compressions, continuing until a doctor arrived. Oscar 3 and the OSG remained whilst Oscar 2 continued attempting to resuscitate The man.

54. The prison doctor arrived at 00.25am as Oscar 2 was performing resuscitation. The doctor pronounced the man's death at 00.25am.

55. The cell was sealed for subsequent examination and retrieval of exhibits by the police. The police arrived at 1.30am, and remained until 4.24am. The funeral directors arrived at 3.45am and departed at the same time as the

police. A hot de brief of the staff involved in the discovery and resuscitation of the man was held after the funeral directors had left the prison.

56. The news of the man's death was broken to his mother by the police.

57. An impromptu memorial service for the man was held in the chapel later that morning (Sunday 22 October), attended by prisoners and staff. The teacher was asked to purchase a remembrance card for the prisoners in his workshop, and spoke at the memorial service.

58. After the man's death, prison staff listened to the telephone calls that the man had made in October. They were of the opinion that there was nothing of significance that could have given anyone any indication that he intended to take his life.

59. When a prisoner was asked if the man had given him any indication that he was upset about anything, he said that the man alluded to a dispute over his late father's estate. However, during the week prior to his death, the man was happy. The prisoner had not seen the man take drugs in prison, although he was told that he had. The prisoner said that he cried when he was told of the man's death. He subsequently went to a second memorial service in the chapel which was attended by the man's mother, staff and prisoners from different wings. He organised a sympathy card and got everybody in the workshop to sign it. He briefly spoke to the man's mother at the service, and described the service as nice. The prisoner felt well supported by staff and other prisoners.

60. Another prisoner heard of the man's death the following morning as he was unlocked. He was shocked as the man had given him no indication whatsoever that he intended to take his life.

61. One of the man's personal officers was told of the man's death when he arrived for work on the Sunday morning. He says that he was absolutely gutted, as there was no indication the day before and he could not understand it. He said that normally prisoners would tell officers if they had concerns about fellow prisoners and this did not happen

62. The prisoner in the cell next to the man's said he was completely shocked. He could not recall anything different about The man's demeanour, apart from playing his music loudly on the Saturday before his death.

63. During the morning of 22 October, a prisoner saw the activity around the man's cell. He knew that someone had died, and was shocked to hear it was the man. The prisoner said he knew that the man ad taken illicit drugs and alcohol whilst at Everthorpe.

64. The prisoner who lived opposite the man's cell was told of the man's death during the morning of 22 October. He said he felt completely empty. He said he cried for an hour as he could not believe that it had happened and he

expected the man to walk through his cell door. He wrote some lyrics and attached them to the man's cell door as a mark of respect for his friend.

65. The prisoner who lived opposite told my investigators that the track that was playing when the man was discovered in his cell was from Mobb Deep's album 'The Infamous' (1995). I note that one track is entitled Cradle to the Grave, but can otherwise identify no special significance in the lyrics. It is not known which particular track was actually playing when the man was found.

66. The teacher was not at work during the weekend the man died, and was told of the man's death when he returned on the Monday. He too was shocked when he heard the news and could not believe it. He said that the man seemed fine when he last saw him on Friday morning, and had given no indication that anything was any different.

67. The man's mother was shocked to learn of her son's death, and does not believe that he intended to take his life. She has been in contact with the prison and attended a memorial service in memory of the man's life which was attended by the Governor, his staff and prisoners. The man's mother has described the support she received from Everthorpe as fantastic. The Governor and the prison's family liaison officer met the man's mother personally and facilitated her visit to the prison. The Governor gave the man's mother his direct telephone numbers and the prison offered to contribute to the man's funeral costs.

POST MORTEM

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68. A post mortem examination on the man took place at Hull Public Mortuary on. The toxicology results were:

Ethanol	5mg/100ml
Paracetamol	Not detected
Salicylate	Not detected
Opiates	Not detected
Benzodiazepines	Not detected
Barbiturates	Not detected
Cannabinoids	Not detected
Methadone	Not detected
Cocaine metabolites	Not detected
Phenethylamine	Not detected
Morphine	Not detected

Contents: A negative toxicological screen.

The post mortem concluded:

1. That the man's body was that of a well nourished young man with no natural disease that would have contributed or caused death.
2. The pathological findings are those of hanging, in keeping with the given circumstances.
3. The pattern of ligature mark is indicative of self infliction.

He gave the cause of the man's death as hanging.

ISSUES CONSIDERED IN THE INVESTIGATION

Clinical care

69. The clinical review has found that the history and assessment of the man's injury on 26 April 2006, and his refusal to have treatment on 27 July for another injury, should have indicated to staff that the injuries were of a serious nature. A report of injury to inmate form was not completed by either the prison officers or healthcare staff, and as a consequence a referral to the Safer Custody Team was not made. Although the man refused treatment on 27 July 2006, no questioning as to the history of the injury or a further follow up to see if the man had changed his mind regarding receiving treatment was made.

The Governor should increase the awareness of all prison staff regarding the signs and symptoms of suspicious injury and the process to follow when one is suspected.

70. The clinical reviewer recognised that, if a member of the general public were to refuse treatment, it would not be followed up as a matter of course. However, in the prison setting, due to the fact that the exact nature of the injury and an assessment of the extent of the injury had not been made, it should be deemed good practice to follow up prisoners who refuse treatment.

The Head of Healthcare should remind healthcare staff of the need to improve the clinical assessment and documentation of injuries.

71. Upon the man's arrival at Everthorpe, the healthcare questionnaire indicates that the man was not asked about previous mental health problems and self harm/suicide attempts. The fact that the man had recently suffered bereavement was also not documented. It would appear that no review was undertaken of his notes from Doncaster, where a previous self harm attempt was documented along with details of his recent bereavement.

72. Had these facts been identified by healthcare staff upon transfer, the man would have been offered a referral for a mental health assessment. It is noted that the member of staff completing the healthcare questionnaire was a newly employed member of staff who did not have previous experience of working in a prison healthcare setting.

The Head of Healthcare should review their process for undertaking the initial healthcare assessment to ensure a review of previous records is also undertaken.

The Head of Healthcare should review the induction process for newly appointed staff to include a period of preceptorship and a documented process for indicating clinical competence.

73. The prison may wish to give consideration to the support it offers prisoners who are recently bereaved either immediately prior to coming into prison or

during their sentence. It would appear from a review of the records that limited support was offered to the man following the death of his father.

The Governor should review the service offered to prisoners in respect of support given following a recent bereavement.

Records and record keeping

74. The findings from the clinical review would indicate that, although all entries in the records were in chronological order and signed, the general standard of records and record keeping could be improved as noted by the following:

- the prescribed drugs on the Prescription and Administration record chart dated 12 July 2006 and the accompanying instructions for use were for the most part illegible;
- some of the entries in the notes were illegible;
- most entries did not document that a full assessment had been undertaken;
- alterations to entries had not been signed or dated;
- the time that the entry had been made was not documented in the majority of the cases.

The Head of Healthcare should undertake a clinical audit of patient records based upon the National Medical Council (NMC) Standards for record keeping in 'Just for the Record'.

Antibiotic prescribing

75. From the date of the man's admission to prison in May 2004 until his death 29 months later in October 2006, the man was prescribed antibiotics on five occasions. It is acknowledged that the clinical assessment may have indicated the need for antibiotics, however it is suggested that a review of antibiotic prescribing and guidance regarding appropriate prescribing is issued to prison healthcare to ensure that they are or continue to be prescribed appropriately.

The Head of Healthcare should review the prescribing of antibiotics in prison healthcare and promote the use of the recently approved antibiotic prescribing guidelines.

Good practice

76. The clinical reviewer has commented that the man's requests to see the doctor were generally acted upon within what would appear to be a reasonable timescale. The reviewer has also said that, when the man was ill with 'flu like symptoms', his illness was managed in a caring and patient

centred manner. Finally, the man's death was immediately reported to the PCT so that an immediate review of the man's healthcare could be undertaken.

77. The clinical reviewer concluded that the care the man received was equitable with that of the wider community. The reviewer also recognised that healthcare staff are already undertaking specific actions in relation to the recommendations she has made.

The personal officer scheme

78. The personal officer scheme at Everthorpe works very well with the assigned personal officers having a good rapport with, and knowledge of, their allocated prisoners. The staff/prisoner relationships were some of the best and most professional that my investigators have witnessed.

Access to drugs in prison

79. From the interviews my investigators conducted with both prisoners and staff, it would seem that both illicit drugs and illicitly brewed alcohol are available to prisoners. Everthorpe is scarcely unique in this regard, and I understand the Governor is working hard to stem the supply through drug reduction strategies and the detection of offenders. However, I am particularly concerned about the abuse of subutex, a substance not routinely screened under the Prison Service's mandatory drugs testing programme. Given the circumstances giving rise to this report, this may not be the most appropriate place to make a formal recommendation to the Prison Service in respect of testing for illicit use of subutex. However, the Governor may wish to draw my concerns to the attention of his area manager.

Resuscitation

80. The response of prison staff to finding a medical emergency is rarely acknowledged in public. I am pleased to use my reports to remedy that unfairness. As I have detailed earlier, the reaction of the night staff on duty when the man was found was first rate.

The staff should be commended by the Governor for the way they dealt with the discovery of the man's body.

81. I note that Oscar 2 administered mouth to mouth resuscitation and chest compressions at a cycle of two breaths and 15 chest compressions. I intend no personal criticism of Oscar 2 who, like his colleagues, responded with great care and professionalism to the emergency he faced. I am also doubtful if it made any practical difference to the outcome. However a ratio of two breaths to 15 compressions is not in line with the current guidelines of 30 chest compressions to two rescue breaths.

The Governor should remind staff of the recommended guidelines for resuscitation.

Support to staff and prisoners

82. Staff and prisoners felt well supported after the man's death. Those involved that night attended a hot debrief and were offered support from the prison care and welfare team. Prisoners felt generally well supported by the staff, the chaplaincy and other prisoners. Two memorial services were held at the prison, the first on the morning of the man's death and the other some days later which was attended by his mother, staff and prisoners.

CONCLUSION

83. The man gave no indication to anyone that he intended to take his life. He was a popular prisoner amongst other prisoners and with staff.

84. His mother had three theories about the circumstances leading to his death:

- The man might have been acting out something he had seen on the internet to get a buzz and it went wrong.
- The man wrote rap music and might have been acting out the lyrics to be able to write about the experience more vividly.
- The man had taken mind altering drugs.

85. My investigation has found no evidence to verify any of these theories. I have found no evidence that the man had seen anything on the internet whilst at Everthorpe. Second, while it is known that the man wrote rap lyrics and listened to rap music, and his lyrics folder has been seized by the police as part of their investigation, it is not known what song was playing when he died and I can find no special significance in the lyrics of the album 'The Infamous' by Mobb Deep. Third, there is no evidence from the toxicology results that the man was suffering the effects of mind altering drugs.

86. On the other hand, my investigation has found some evidence of the man's likely previous self-harming behaviour. That said, I am unable to surmise what was going through his mind at the time of his death. His loss shocked everyone who knew him.

RECOMMENDATIONS

1. The Governor should consider whether all staff who work with prisoners when the healthcare centre is closed should be qualified to administer first aid.

2. The Governor should increase the awareness of all prison staff regarding the signs and symptoms of suspicious injury and the process to follow when one is suspected.

3. The Head of Healthcare should remind healthcare staff of the need to improve the clinical assessment and documentation of injuries.

4. The Head of Healthcare should review their process for undertaking the initial healthcare assessment to ensure a review of previous records is also undertaken.

5. The Head of Healthcare should review the induction process for newly appointed staff to include a period of preceptorship and a documented process for indicating clinical competence.

6. The Governor should review the service offered to prisoners in respect of support given following a recent bereavement.

7. The Head of Healthcare should undertake a clinical audit of patient records based upon the National Medical Council (NMC) Standards for record keeping in 'Just for the Record'.

8. The Head of Healthcare should review the prescribing of antibiotics in prison healthcare and promote the use of the recently approved antibiotic prescribing guidelines.

9. The staff should be commended by the Governor for the way they dealt with the discovery of the man's body.

10. The Governor should remind staff of the recommended guidelines for resuscitation.

Everthorpe has accepted these recommendations and drawn up an action plan to implement them by the end of 2007.

The man's inquest was concluded at Hull Coroners Court on 17 April 2007 and the jury concluded that the man's death was an accident.