Investigation into the death in October 2006 of a man who was a prisoner at HMP Albany

Report by the Prisons and Probation Ombudsman for England and Wales

May 2007

This is the report of an investigation into the death of a man who was a prisoner at HMP Albany. The man was found hanging in his cell at the prison in the early hours on the morning of 23 October 2006.

I extend my condolences and those of my colleagues to the man's family. I know that his passing will have caused much grief for his family and friends, and I hope this report goes some way to answering the questions they may have.

This is the first apparently self inflicted death that I have had to investigate at Albany since my office started investigating all deaths in prison custody in April 2004.

The investigation was undertaken on my behalf by one of my investigators. In addition, a clinical review was conducted by the Isle of Wight NHS Primary Care Trust. I am most grateful to the doctor who completed the review. I am also indebted to The governor and staff at Albany for their cooperation and assistance with my investigation. I would particularly like to thank the Head of Security and the Governor's secretary.

It is evident from my investigation that the man who died was a quiet man who, for the most part, kept himself to himself. He was respectful and friendly to both staff and prisoners and appeared generally settled at Albany. However, due to circumstances mostly beyond his own control, it is apparent that the man who is the subject of this report had much on his mind during the last few weeks of his life. Although no one can be sure of the reasons why he appears to have taken his own life, I believe that the domestic problems he was experiencing at the time were a substantial contributory factor.

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

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SUMMARY

The man who died was received into custody on 27 October 2004 at HMP Dorchester. Prison documents noted that the man had a history of depression and self harm but recorded that he was not suicidal at the present time. The man was admitted to the healthcare centre overnight before being located on the vulnerable prisoners' wing.

On 28 October, the man told staff that he had cut himself. In response to his actions, staff at Dorchester began monitoring and supporting the man under arrangements for prisoners who are thought to be at risk of suicide or self harm. On 4 November, he was transferred to HMP Albany.

During the reception process at Albany, it was noted that the man suffered from a "mental condition" and was vulnerable. During a consultation with a medical officer on 5 November, it was recorded that he had been depressed but had no suicidal thoughts at that time. At a case review on 10 November, the decision was taken that the man's risk of self harm had reduced sufficiently for the special monitoring and support arrangements to be ended.

Between December 2004 and September 2006, the man appears to have led a quiet and untroubled life at Albany. There is little in his prison record to suggest otherwise. However, on 29 September 2005 during a cell search, a large quantity of paracetamol tablets was found in his possession.

On 9 September 2006, the man received news that his wife had been involved in a car accident on her way to visit him. On 24 September, he learned from his parents that his wife had not been involved in an accident but was seeing somebody else. Because of the man's record of self harm, staff were informed.

In the weeks leading to his death, the man made a number of calls to his parents and his wife.

On 21 October, the man wrote a last will and testament, along with a number of other letters that were found in his cell after his death. The man spoke with his mother for the last time on the morning of 22 October. It was noted by an officer on the wing that the man was laughing and joking with other prisoners that day.

In the early hours of 23 October, the man was found hanging in his cell. Emergency life saving assistance was given, but the man was pronounced dead by paramedics at 5.30am.

My report makes a number of recommendations to the Governor at Albany.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened by one of my investigators.

2. Notices announcing the investigation were issued to both staff and prisoners informing them of the investigation and its terms of reference. These were displayed around the prison and invited staff and prisoners to contact the investigators should they wish to do so.

3. My colleagues visited Albany and were given full access to all areas of the prison. They met with a number of governors as well as with members of the Independent Monitoring Board. My investigators also made themselves known to two representatives of the local branch of the Prison Officers' Association. The investigators obtained documentation relating to the time that the man spent at both Albany and his local establishment, and interviewed a number of staff and prisoners who had had contact with him. During their visit to Albany, my investigators also met with a Police Liaison Officer and a Detective Sergeant from the Hampshire Constabulary.

4. I commissioned a clinical review from the Isle of Wight NHS Primary Care Trust, and one of their doctors kindly completed this on their behalf.

5. My investigator and one of my family liaison officers met with the man's parents at their home in November 2006. The man's parents raised a number of issues with my family liaison officer and investigator. I trust that my report will address these matters satisfactorily and any other questions that the man's family may have.

6. A copy of this report will be sent to the Coroner to assist him with his enquiries.

HMP ALBANY

7. Albany is a category B training prison built on the outskirts of Newport, Isle of Wight, in the early 1960s. It was previously part of the high security estate. Albany holds sex offenders and other vulnerable prisoners, and operates as an assessment centre for the core sex offender treatment programme.

8. Up to 526 prisoners can be held at the prison. The principal accommodation comprises five four-storey cell blocks designated A to E wings. (These wings are identical and hold a maximum of 88 prisoners in single cells. There is no in cell sanitation. However, prisoners have access to sanitation at night by the use of electronic unlocking.) In May 2003, a unit holding 80 category C prisoners was opened; each of the cells in this unit has in cell sanitation.

9. Health services at Albany and at the other two prisons on the Isle of Wight are delivered by the Isle of Wight NHS Primary Care Trust. Healthcare at Albany is based on primary care and operates from 8.00am to 9.00pm daily.

10. Albany was last inspected by Ms Anne Owers, HM Chief Inspector of Prisons, on 25 October 2005. She reported that Albany remained an essentially safe establishment and had improved the availability of purposeful activity. Ms Owers's comments about healthcare provision were less favourable. She said:

    > "Although progress had been made since the last inspection in some healthcare areas, many had either stood still or regressed. The perception of patients we spoke to was that healthcare generally had deteriorated and was poor. This was in contrast to the last inspection when 53% of prisoners in our survey thought that healthcare was good or very good."

11. The death of the man subject to this investigation is the first apparently self inflicted death to have taken place at Albany for a decade. My office has investigated six deaths from natural causes at the prison since April 2004, the most recent being in October 2005.

KEY FINDINGS

12. The man who died at Albany was sentenced to twelve years imprisonment at Crown Court in 2004. He was received into custody at Dorchester prison later that day. The Prisoner Escort Record (PER – a form that accompanies staff on all escorts and provides a chronological record of the escort and also advises staff about the risks of an escort or transfer) recorded that the man was at risk of suicide/self harm, that he was taking medication and that he suffered from depression. A Suicide Self Harm Warning Form was also completed by escort staff. This recorded the man's history of depression and self harm. I note that staff at the local prison did not fully complete this form, although the man's history of depression was recorded on several other documents.

13. During the reception process at the local prison, a personal summary sheet (F2050 – Page 1) was completed and the man's personal details were recorded by staff. The man gave his mother's name and address as his next of kin and also as the person to be notified in an emergency. A Cell Sharing Risk Assessment (CSRA – a form used to assess the level of risk that a prisoner would be to other prisoners when sharing cells) was also completed by staff. It was recorded on the CSRA that the man was "not suicidal at present". Nevertheless, due to the length of his sentence, he was to be admitted to the healthcare centre overnight. The following day, the man was placed on the vulnerable prisoners' wing under Rule 45. (Prisoners who have committed an offence of which other prisoners disapprove are frequently segregated from the remainder of the population under Rule 45.)

14. As part of the reception process, all prisoners entering prison are given a first night reception health screen. This is based upon information given by the prisoner himself. The nurse who conducted the man's assessment at the local prison noted that he had recently seen a doctor for neurological damage and depression, and was receiving amitriptyline and fluoxetine. (These drugs are primarily used in the treatment of depression. However, in lower doses I understand that they can be prescribed to alleviate pain.) The nurse noted that the man had suffered from a nervous breakdown seven to ten years previously, and that he had attempted to self harm five years before. The man was currently taking 20mg of fluoxetine for the treatment of his mental health problems. Another health screen, completed the following day, noted no concerns.

15. Shortly after midnight on 28 October, the man rang the bell in his cell in order to tell staff that he had cut himself. Healthcare staff attended and superficial lacerations made to his right wrist were cleaned and dressed. During his treatment, the man complained to staff that he had not received his fluoxetine for three days.

16. The man was seen by a doctor at the local prison later that day. In addition to noting some of the man's general medical issues, the doctor recorded that the man's mental condition was stable, that he had minimally self harmed the previous evening, that he denied any thoughts of self harm and that he was

not clinically depressed.

17. Staff completed the relevant documentation in light of the man's attempt to self harm, and opened an F2052SH booklet on him and he was monitored hourly. (An F2052SH is a document used by the Prison Service to monitor, support and assess those prisoners at risk of self harm. It has recently been replaced by the Assessment Care in Custody Teamwork form – (ACCT).) Nursing staff noted in the booklet that there was a clinical risk of self harm and that the man had a poor level of coping. During a case review on 30 October, the man spoke of a recent family visit and news of a possible appeal. He described himself as feeling vulnerable and talked of his history of self harm and depression. The man remained on hourly observations.

18. On 3 November, an entry by an officer in the man's wing history sheets noted that he was:

> "… seen for transfer. Still not very happy after OCA [Observation, Classification and Allocation – the prison department that arranges transfers] informed him, due to family reasons and [the man] thinking he would stay at [the local prison] until appeal is heard."

19. On 4 November, the man was transferred to HMP Albany. His PER form noted that he had a mental condition, was vulnerable and was on an open F2052SH. The CSRA form completed upon his arrival at Albany noted that it was the man's first time in prison, and that he was:

> "A very private man who has been shell shocked with what has happened over last month."

20. At approximately midday on 4 November, the man was seen by a nurse at the prison. She wrote in his IMR [Inmate Medical Record] that he was upset but had no feelings of self harm, and that he seemed calm when spoken to. The nurse noted the man's neurological problems and gave him a dose of his prescribed medication. She told the man that he needed to attend the medication hatch for further medicines. The nurse also recorded on the CSRA that it was the man's:

> "First time in prison therefore never shared a cell, prefers to be alone. On an open 2052. When in [local prison] self harmed 28 October 2004."

21. An entry in the man's wing history sheets on 4 November records that he was very concerned about the future, had started his appeal process and completed his induction. It was also noted that he had concerns about his wife who had recently sold their house and whom the man was helping to move abroad.

22. On 5 November, the man was seen by the prison doctor, who recorded:

> "Transferred from [Dorchester]. Has an appeal ongoing. Has been

depressed and had one episode of self harm. No suicide thoughts now. Gives a good account of himself, has ongoing medication – see chart."

23. At an F2052SH case review held at Albany on 10 November, it was recorded that the man was taking his medication regularly, and that he was feeling a lot better and beginning to settle in. It was noted that the man was hopeful about his appeal and in the meantime was getting on with his sentence. The decision was taken to close the F2052SH booklet.

24. On 11 November one of the prison doctors at Albany, wrote to the man's GP in his local town requesting information about the neurological disorder from which he had suffered.

25. Between December 2004 and September 2006, the man appears to have led a quiet life at Albany. There is little on his prison record to suggest otherwise. General entries on his wing history sheets and other information suggest that the man kept himself to himself, was respectful towards staff and associated well with other prisoners. Comments noted on his record include: no problems to report, no cause for concern, and that everything was okay. On 14 December 2004, an officer recorded that the man was "a quiet man but not afraid to ask staff for help if he needs it."

26. On 29 September 2005 during a cell search, staff found 98 Paracetamol tablets in the man's cell. The tablets in excess of those that had been prescribed to him were removed and returned to the healthcare centre. The Security Information Report (SIR) completed by staff about the discovery said that, with his history of self harm, possession of such a quantity of painkillers was a matter of concern. The report suggested that wing staff and healthcare staff keep an "eye on this prisoner".

27. On 9 September 2006, an entry in the man's wing sheets noted:

> "Wife in accident on way to visits. Given phone call to [local] hospital, wife discharged herself, at home now. Phoned home all ok at moment. Poss[ible] phone call tomorrow."

28. On 23 September, staff attempted to phone the man's wife as she had not turned up for a visit and was not answering the phone. On the following day (24 September), it was recorded that the man:

> "Got in touch with his mother and father. They told him his wife was not involved in an accident (ref entry 9-9-06) … said she was seeing someone else. Has taken this news badly but had a long talk to him and he says he is now alright. But be aware has record of self harm. Staff informed."

This was the last entry made on the man's prison record.

29. During the week leading to his death, the man made a number of telephone calls to his wife and parents. On 18 October, he spoke with his wife twice. During their conversation, the man implied that he had taken an overdose of his medication and spoke of his fears that he would receive a “Dear John” letter from her. (A “Dear John” letter is one in which a prisoner is told that his relationship with his wife or partner is at an end.) The man also spoke with his parents that day.

30. Early on 19 October, the man spoke briefly to his wife. He attempted unsuccessfully to contact her again at around lunchtime. At 1.15pm, the man spoke with his friend. During the call, the man asked about his wife, indicating that he believed she was conducting an affair with another man. When asked by his friend how he was doing, the man said that he was doing as best he could. He added:

    > “Don’t really see much point in going on much longer, but there we go.”

    The man’s friend told him that he should “hang on in there”.

31. At 1.36pm on the same day, the man spoke with his mother again. He asked her to drive past his wife’s address in order to confirm whether or not she had moved out. The man expressed concern to his mother that his wife was spending unauthorised amounts of his money by the use of his credit cards. The man spoke with his mother later and she confirmed that his wife was still living at their home. That evening, the man spoke with his parents once again. He said he would draw up a list of possessions that remained in his home and that he wanted back. The man made several unsuccessful attempts to contact his wife during the afternoon and evening of 19 October.

32. On 20 October, at about 1.37pm, he left a message on his wife’s mobile phone saying that he would call her back later that day. The man made further, unsuccessful, attempts to contact his wife that afternoon. At 5.01pm the man spoke with his mother.

33. Throughout 21 October, the man attempted on numerous occasions to contact his wife by phone. At 10.59am, he rang his mother. They spoke generally of things that had been going on and about the man’s wife. The man told his mother that he had compiled a list of possessions he wanted to be collected from his home, and that he had put this list in the post to her. The man spoke with his father at 4.00pm. During this conversation, the man talked of a letter that he had received from his wife earlier that day. The letter said that, due to the problems she had been experiencing whilst he had been in prison, she was no longer able to continue with their relationship. The man told his father that she had met a “new man”. He also said that, as their landlord was going to evict her from their home in December, he would need to move his possessions from the property.

34. The man wrote and addressed a last will and testament, dated 21 October, to his solicitors. This was one of the letters removed by the police from the man’s cell after the discovery of his body. The other letters were addressed

to his parents and wife. I understand that the police removed the letters before prison staff were able to read their contents. As a the man's parents did not receive their son's "last will and testament" along with the other letters until some time after his death.

35. The man spoke with his mother for the last time on Sunday 22 October at 8.57am. They again talked about his wife. The man concluded the call by saying that he would speak with his mother again the following Tuesday afternoon.

36. An officer on B wing said that the man was laughing and joking with other prisoners on the Sunday evening.

37. My investigators spoke to a number of staff and prisoners at Albany who knew the man. The officer who had seen the man laughing and joking described him as a:

    > "quiet individual, no problems whatsoever, polite, respectful."

    Another officer from B wing described the man who died as:

    > "A very polite, mature person, always polite, seemed jovial with staff and to his peers."

    An instructor at Albany described the man as a hard working individual who was trustworthy and who volunteered to do additional unpaid work in the workshops.

38. However, it is also clear from what my investigators were told by both staff and prisoners (and in light of correspondence between the man and his wife), that about three months before the man's death he began to experience substantial marital problems. The man often spoke about these difficulties to other prisoners and they preyed on his mind. These difficulties culminated in the "Dear John" letter that the man received from his wife on 21 October.

39. Approximately two weeks before his death, the man spoke with a fellow prisoner. This fellow prisoner told my investigators that the man who is the subject of this investigation had told him how he believed his wife was leading him a "merry dance". The fellow prisoner said that he was also aware that the man had received a "Dear John" letter from his wife and that he was upset about this. The fellow prisoner said that he had been shocked on learning the news that the man had apparently taken his own life. He said that there had been no warning and nothing appeared to be wrong with the man, whom he described as being upbeat and positive about his forthcoming appeal. Other prisoners who knew the man who died spoke similarly of their experience and knowledge of him.

40. An OSG confirmed with my investigators that on the evening of 22 October, at approximately 8.00pm, he completed a roll check of the wing, checking

numbers and noting that there was nothing out of place. The OSG said that this was the last time that he saw the man alive.

The discovery of the man's body

41. At approximately 5.03am on the morning of 23 October, whilst carrying out the morning roll check, the OSG checked the man's cell. He said that, on looking through the cell door, he could see what appeared to be the man sitting under the window. In his incident report, the OSG said that he could see a fine cord leading down towards the man's neck and immediately tried to gain a response from him. The OSG told my investigators that, seeing blood coming from the man's nose, he ran downstairs to the wing office, leaving the gates behind him open. On reaching the office, the OSG said that he telephoned the control room (Comms) to obtain assistance from the night orderly officer. (During night shifts in prison, the night orderly officer is more commonly known as Oscar 1 and his deputy as Oscar 2). An entry in the control room log at 5.06am records that:

    "Informed inmate 5253 Hanging in cell. Ambulance called."

42. The OSG told my investigators that, upon the arrival of other officers, call signs Oscar 2 and Oscar 1, a few minutes later they left the wing office to return to the man's cell. The OSG said that he took the emergency self harm response kit with him. On arrival at the man's cell, the OSG said that the door was electronically unlocked by control room staff. (Unfortunately there is no definitive record as to when the cell door was unlocked. The entry in the control room log simply records that at 5.06am the man had been found hanging in his cell.) The OSG explained that, on entering the cell, Oscar 1 and Oscar 2 raised the man slightly so they could cut the ligature from the man's neck.

43. When asked during interview if he was aware of any guidance with regard to entering cells at night, the OSG said that he was not. He went on to say that during training he was told that he was unable to enter a cell on his own anyway, and that only Oscars 1 and 2 could do so.

44. Oscar 2 told my investigators that, at about 5.00am when he was just about to check the alarm bells, a message came from the control room to attend B wing as soon as possible. (Albany does not have a code system of alerting staff to the type of incident they are about to attend.) Oscar 2 said that, on reaching the B wing office, he was met by the OSG who advised him of the suspected hanging on the 4th landing. Oscar 2 said that it was about two minutes from the time he received the original emergency call to when he reached the man's cell.

45. Upon arriving at the cell, Oscar 2 said he looked through the flap, suspecting that the man had hanged himself. He said that Oscar 1 then looked in, and on doing so immediately contacted the control room, requesting that the cell door be unlocked electronically. On entering the cell, Oscar 2 said that he assisted in cutting the man down, and confirmed that it was at this time that

Oscar 1 called for an ambulance before commencing cardio-pulmonary resuscitation (CPR).

46. Oscar 1 was in the centre office at around 5.00am when a call to attend B wing was received from the control room. Oscar 1 said that it took about two minutes to get from the centre office to the man's cell, adding that Oscar 2 was about twenty seconds in front of him. Oscar 1 said that on reaching the cell he immediately asked the control room to unlock the cell door electronically.

47. Oscar 1 assisted the other officers present in cutting the man down. He then checked for a pulse and any signs of breathing. He explained to my investigators how he tried to give the man mouth to mouth resuscitation alone, but was unable to do so as the man's jaw was shut tight and he could not open his mouth. Oscar 1 said that he proceeded to give chest compressions and attempted to administer oxygen through the man's nose instead. He said that he continued with CPR, but as there were no signs of life he placed the man in the recovery position and waited for the arrival of paramedics.

48. According to the control room log, the ambulance arrived at Albany at 5.22am, and the paramedics were in attendance at the man's cell at 5.25am. The man was pronounced dead by the paramedics at approximately 5.30am.

49. As well as the last will and testament written by the man on 21 October, a number of other letters were discovered in his cell after his death. These included two letters to his mother and father, and one each to his brother, sister and wife. One of the letters to his parents was written on the afternoon of Sunday October 22. The man wrote in it about how he had lost everything. In part of the letter, The man said:

> "I have to go and get my tea now and I hope they don't see how upset I am. I got some funny looks but that's all."

50. My investigators spoke with prisoners who occupied cells on either side of the man, asking if they had heard anything unusual that night. One of the prisoners said that he had heard a bang in the early hours of the morning, describing it like a chair falling over. The other prisoner said he heard nothing in the night other than voices on the landing at about 5.30am.

51. A governor told my investigators that a hot-debrief took place that morning and was attended by a number of staff who had been involved in the discovery of the man. A review of all prisoners on open ACCTs was also completed. Staff who had attended the man were offered the facilities of the prison's welfare team.

52. At 10.20am, a chaplain from Albany informed the man's parents, by telephone, of their son's death. A governor along with the chaplain visited the man's parents at their home that afternoon. On the following Friday (27 October), the man's parents visited Albany with other family members and saw the cell in which their son had died. During the visit, the man's family

also met with some of his friends on the wing. The man's parents spoke to my family liaison officer and investigator positively about the help and support received from staff at the prison, in particular from the chaplain and Head of Security. The prison made a significant contribution towards the funeral expenses.

Clinical Review

53. The clinical review was undertaken by a doctor on behalf of the Isle of Wight Primary Care Trust. I summarise the doctor's findings in the paragraphs below.

54. During his time in prison, the man had been extensively investigated for orthopaedic and neurological symptoms and his care was equitable with that expected in the wider community. There was no evidence to suggest that the man did not have access to healthcare in Albany.

55. In February and July 2006, the man probably complained of pain rather than depression. Extensive investigations were made between 2002 and 2004 into the man's orthopaedic and neurological symptoms. During his time at Albany, the man had been able to undertake daily living activities satisfactorily.

56. Prescription and commonly abused drugs were not found in above therapeutic levels in the man's blood taken during the post mortem and were not, therefore, directly involved in his death.

57. The attending paramedics acted appropriately in not attempting to resuscitate the man.

58. The care provided to the man for his depression was broadly equitable with that provided in the community, but there was room for improvement. In addition, the doctor commented on the need for the PCT's clinical governance department to review the operation of the VISION system at the prison. (VISION is the system that electronically records prisoners' healthcare notes and their contact with healthcare staff at the prison.)

59. The doctor makes four recommendations:

    The primary care service for the Isle of Wight prisons should be asked to produce a policy on the prescribing and review of prisoners on antidepressant medication, including a consideration of who is best placed to undertake reviews by the end of August 2007.

    That a screen [on the VISION system] should be set up to structure the review of patients prescribed antidepressants for moderate to severe depression. The screen should be implemented with suitable training for staff by the end of October 2007.

    That the operation of the VISION system should be reviewed by the PCT's clinical governance department by end of December 2007.

That the scheduling and calling of prisoners for mental health and other primary care return visits should also be reviewed by the end of March 2008.

60. The doctor also concluded that consideration should be given to the training of prison staff in resuscitation and that the management of prisoner held medication should be reviewed.

Post Mortem Report

61. A post mortem was conducted on 24 October. It gave the cause of death as hanging.

ISSUES

62. Just after 5.00am on the morning of 23 October, the OSG noticed that something was wrong when he checked the man's cell. The OSG returned immediately to the wing office in order to phone for assistance, remaining at the office until help arrived. Upon the arrival of Oscars 1 and 2, all three members of staff returned to the man's cell, taking with them the emergency self harm response kit. On confirming that the man was in need of urgent assistance, his cell was unlocked by the control room.

63. Section 7 of Albany's local instructions sets out guidance for staff who discover a prisoner who has attempted to self harm during the night. It says that:

> "Night Operational Instructions must make clear, that if a cell must be unlocked, two members of staff must be present, except in an obvious emergency where there is an immediate danger to life."

64. It is clear that the members of staff who attended to the man in the early hours of 23 October did so in accordance with the locally approved policy. However, the locally approved policy relating to the entering of cells at night appears to be at odds with the local suicide prevention policy. Both lack clarity in explaining to officers the requirements of the relevant Prison Service Orders.

    I recommend a review of sections 7 and 8 of Albany's local instructions (attempted suicide and death in custody) with particular focus on the circumstances in which a cell may be unlocked during the night and the staffing level that is required.

65. Of the staff who attended to the man, only Oscar 1 had received up to date first aid and CPR training. Oscar 2 had received training approximately five years previously, and the OSG had undergone first aid training in previous employment. Given the evidence of Oscar 1 that the man's jaw was locked and that he showed no vital signs, I believe that nothing further could have been done to save the man's life even if all the staff had had up to date training in CPR. However, in view of the low levels of staff on duty at night, and the absence of any healthcare staff, I make the following recommendation.

    I recommend that the Governor gives consideration to training all night duty OSGs in basic CPR techniques.

66. During the investigation, my staff learned that a defibrillator of the type which can be used by the general public and which requires no formal training before use, is kept in the healthcare centre at Albany. My investigators asked a number of officers about the defibrillator. Many were not aware of it. Others were aware of it but were unsure as to how it could be accessed.

    I recommend that the Governor in conjunction with the Healthcare

Manager considers the training of night staff in the use and location of the defibrillator.

67. My investigators noted that the post incident log was not begun until the arrival of the Duty Governor at 5.55am. In addition, the incident log kept by the control room had been poorly completed.

    I recommend that the Governor reminds all staff of the importance of completing accurate, timely and comprehensive logs.

68. Overall, I cannot say that there were any obvious signs that staff should have picked up that the man was planning to take his life. In fact, on the evening before his death he was seen laughing and joking with other prisoners. There can be no way of telling if this was a deliberate attempt by the man to mislead staff and prisoners as to his intentions or whether he was at peace with the decision he had made.

RECOMMENDATIONS

I recommend a review of sections 7 and 8 of Albany's local instructions (attempted suicide and death in custody) with particular focus on the circumstances in which a cell may be unlocked during the night and the staffing level that is required.

Accepted

I recommend that the Governor gives consideration to training all night duty OSGs in basic CPR techniques.

Not Accepted – HMP Albany said that their current arrangements ensure that all Senior Officers are trained in first aid. They say that Night Orderly Officers are always Senior Officers and current arrangements ensure that the first on scene is first aid trained. Given I am simply asking for a review of this matter, I hope that Albany will reconsider its rejection of this recommendation.

I recommend that the Governor in conjunction with the Healthcare Manager considers the training of night staff in the use and location of the defibrillator.

Partially Accepted – The local Primary Care Trust will be contacted in order to seek advice on minimising the risk during the State A night period by the end of April 2007.

I recommend that the Governor reminds all staff of the importance of completing accurate, timely and comprehensive logs.

Accepted

Clinical Review Recommendations

The primary care service for the Isle of Wight prisons should be asked to produce a policy on the prescribing and review of prisoners on antidepressant medication, including a consideration of who is best placed to undertake reviews by the end of August 2007.

Accepted

That a screen [on the VISION system] should be set up to structure the review of patients prescribed antidepressants for moderate to severe depression. The screen should be implemented with suitable training for staff by the end of October 2007.

Accepted in Principle – By October 2007 HMP Albany will recruit suitably qualified psychiatric nurses to ensure that reviews are completed.

That the operation of the VISION system should be reviewed by the Isle of Wight's PCT clinical governance department by end of December 2007.

Accepted in Principle – On behalf of the Primary Care Trust, HMP Albany will bring this recommendation to their attention.

That the scheduling and calling of prisoners for mental health and other primary care return visits should also be reviewed by the end of March 2008.

Accepted