Investigation into the circumstances surrounding the death of a man at HMP Lincoln in November 2006

Report by the Prisons and Probation Ombudsman for England and Wales

July 2007

This is the report of an investigation into the circumstances of the death of a man at HMP Lincoln in 10 November 2006. The man was found hanging in his cell in E wing. He was 31 years old.

I extend my sincere condolences to the man's family and friends for their loss.

The investigation was carried out by two of my colleagues. Lincolnshire Primary Care Trust agreed to carry out a review of the man's clinical care and treatment while at Lincoln. I am grateful to them for completing this review.

I would also like to thank the Governor of Lincoln, and her staff for their help and assistance during the course of this investigation.

The man was accustomed to prison life and nothing arose during the investigation to indicate that he was considering harming himself. There is some evidence that he felt under threat from other prisoners and he made repeated efforts to contact his girlfriend on the morning of his death. Beyond that, there are no clues to his intentions. His death came as a surprise to prison staff, fellow prisoners, and his own family.

Whilst having no bearing on the man's death, I have made one recommendation in this report. I also make two housekeeping points that arise from the clinical review. In addition I have noted one area of good practice.

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

CONTENTS

SUMMARY

The man was 31 years old when he died and he was well used to prison life. He was also known to HMP Lincoln, having served sentences in there in the past. The man had been a drug user for many years and a lot of his crimes were linked to his drug usage. When the man apparently took his own life on Friday 10 November 2006, he had just four months to serve of his latest sentence.

The man's final sentence had commenced on 6 June 2006. It was an 18 month sentence with a conditional release date of 6 March 2007. He man spent the first week of the sentence in HMP Nottingham before being transferred to Lincoln. Seven weeks later, he was transferred to HMP North Sea Camp. The man absconded from North Sea Camp after a few days but was soon re-arrested. On 11 August, he was returned to Lincoln. As with his earlier spell in Lincoln, the man asked to be located in the Vulnerable Prisoners Unit, which is in E wing. His reason for asking for protection was that he was fearful of attack from other prisoners. It seems that these prisoners were friends of people from whom the man had stolen property.

Upon his return to Lincoln, the man quickly settled in. He obtained a job as a wing cleaner and gained enhanced status[1]. The entries made by staff in the man's records report positively on his attitude. The man was described as keeping himself to himself and as someone who gave nothing away about his deeper feelings. Nor did he speak about his girlfriend. This was confirmed by the man's cousin who was in E wing at the same time.

Apart from his work as a cleaner, the man's other main occupation was visiting the gym. From their interviews with staff and prisoners, my investigators found that the man's commitment to work and his interest in the gym did not waver. He gave no hints from these aspects of his life or from any other that there was anything troubling him.

The man's telephone records at Lincoln show that the majority of his calls were to his girlfriend. Between 10.05am and 11.05am on 10 November, the man rang his girlfriend's mobile telephone four times. She did not answer any of the calls. Also that morning, the man separately asked two officers about visits. He asked the first whether he was due a visit that afternoon. Later on in the morning, he asked another officer whether he was due a visit at the weekend. The man was told that no visits had been booked for 10 November but the weekend visits list would not be available until later on in the day. The man did not mention to either officer who he was hoping might visit. Neither officer noticed anything unusual or untoward about the man's demeanour.

One of the other prisoners said that he and the man spoke at about 11.30am. The man asked him for his sausage roll. When the prisoner passed it to him, the man smiled and said thanks.

[1] Prisoners on enhanced status are entitled to more privileges than prisoners on basic or standard regime. A prisoner achieves enhanced status by working hard or going to education and through general good behaviour.

The First Officer was the last person to see the man alive when he locked him into his cell at midday. They each said to the other *'see you later'*. As with everyone else who encountered the man that morning, this officer also said that he seemed his usual self.

When staff unlocked prisoners after lunch the man was found hanging from a ligature tied to the window frame. A Code One alarm was issued to signal a medical emergency, staff entered the cell and cut the ligature. Healthcare staff arrived and attempted to resuscitate the man. They continued with their efforts until relieved by ambulance paramedics who took the man to outside hospital. Unfortunately all efforts proved unsuccessful and the man was pronounced dead at 2.17pm.

The man's death was a shock to all the staff and prisoners who knew him. None of them thought that he seemed someone who would do such a thing and none noticed any change in his demeanour or behaviour. The man's father told my staff that he would not have believed that his son would take his life.

My investigators followed up two reports recording information from prisoners suggesting that the man might have been at risk. One was about the background to the man asking to be in E wing. When my investigators spoke to the prisoner responsible for this information, he was able to add little to what they already knew. The other report suggested that on the morning of his death the man told staff that he was feeling suicidal. This proved to be an unfounded rumour.

THE INVESTIGATION PROCESS

The investigation was opened on 17 November 2006 when one of my colleagues visited Lincoln and met a number of prison staff, including the Deputy Governor, the prison's family liaison officer and a representative from the Prison Officers' Association. My investigator also met the chair and vice chair of the Independent Monitoring Board (IMB). My investigator informed all those he met of the nature and scope of the investigation. Notices were issued to staff and prisoners notifying them of the investigation.

Eight members of staff and five prisoners were interviewed. No additional prisoners came forward to give evidence directly in response to the published notices.

Lincolnshire Primary Care Trust agreed to carry out a review of the man's clinical care and treatment while at Lincoln.

One of my Family Liaison Officers (FLO) contacted the man's father. The FLO and one of my investigators visited the man's father and grandmother. The man's father said that he would never have believed that his son would have taken his own life. And it seemed strange that he had eaten lunch shortly before his death. The man's father had wondered at first whether a third party had been involved. However, he had come to accept that was unlikely because his son was so strong physically it would have taken a number of men to subdue him.

To try to understand whether his son had been planning to take his life, his father wondered whether he had submitted a canteen order in the week of his death and whether he had charged up his telephone credit account. Another thing that he wondered was whether his son had spoken with the prison chaplain.

My investigator obtained copies of the man's last three canteen orders. Monday is the day for submitting orders and the man submitted an order on the Monday before his death as usual. He ordered similar items as previously, including a telephone credit. My investigator found that the prison chaplains had no record or recollection of any contact with the man.

The man's father mentioned vulnerable prisoner status. He was aware that his son had made a number of enemies through his drug use. He wondered if his son had felt in fear for his life and whether this fear of reprisals had been weighing heavily on his mind. After the man's death, his father found a number of letters from his son's girlfriend. He had studied the letters intently, but was unable to pick up any clues as to his son's state of mind.

The man's father said that the way Lincoln handled matters after his son's death had been very good.

HMP LINCOLN

HMP Lincoln opened in 1872. It is a local prison holding just under 500 remand and convicted prisoners. Lincoln comprises four residential units. E wing is a modern wing housing the Vulnerable Prisoners Unit (VPU).

The facilities at Lincoln include production workshops, laundry, education, and vocational training courses. The prison also has charity workshops.

Lincoln has a healthcare centre with in-patient accommodation. Detoxification provision is available in C wing with separate detoxification arrangements for vulnerable prisoners in E wing.

The last inspection of Lincoln by Her Majesty's Chief Inspector of Prisons (HMCIP) was an unannounced inspection in September 2005. Appendix III of the Chief Inspector's report related the findings from prisoner focus groups. Comments from prisoners from E wing included:

> "Officers engage with prisoners during association; some officers play pool with prisoners."
>
> "[There are] no staff bullying issues, but staff can frustrate or goad prisoners."
>
> "Feel safe [from other prisoners] on wing ..."
>
> "[Problem is] mainly frustration with [other prisoners] not bullying."
>
> "[There is] good access to [the] chaplain."
>
> "Cleaners were out of cell all day working and they also had daily association, unlike the rest of prisoners on the wing."
>
> "Not comfortable [with] mixed wing visits – get shouted at by other prisoners."

KEY EVENTS

Events leading up to the man's death

The man's time in Lincoln

On 6 June 2006, the man was convicted on a number of driving offences and was initially received into HMP Nottingham. During a first reception health screening interview, the man said that he had never harmed himself in the past and had no thoughts of doing so now. After spending just over a week in Nottingham, the man was transferred to Lincoln. By the time of his transfer, the man had successfully completed a detoxification programme for heroin and cocaine/crack cocaine.

On arrival at Lincoln on 15 June, the man said that there were prisoners in both B and C wings with whom he would have problems if located in either of those wings. The man asked for protection and he was located on E wing (E wing is Lincoln's vulnerable prisoners wing).

On 31 July, the man was re-categorised and transferred from Lincoln to North Sea Camp (a category D open prison). While in the reception area at North Sea Camp, the man was struck in the face by another prisoner. He absconded two days later.

The man was re-arrested on 11 August and taken back to Lincoln. Upon his arrival at Lincoln, the man was taken though a standard first reception health screening interview. He was asked whether he had ever tried to harm himself in the past and he said that he had not done so. The man was also asked whether he had any present thoughts of self-harm and he replied that he had no such thoughts. He did report, however, that he had been assaulted at North Sea Camp and said that he had fears for his safety. He applied for protection under Prison Rule 45. As with his previous time in Lincoln, the man was located on E wing in a single cell.

The man had been using illicit drugs while out of prison so he was prescribed an opiate detoxification programme which was completed on 18 August. He later declined services offered by the CARATS (Counselling Assessment Referral Advice Throughcare) team, saying that he did not consider drugs to be a problem for him.

On 5 September, the man started work as a cleaner and he quickly proved himself to be a good worker. An officer recommended the man for enhanced status on 15 September recording that: *'[The man] has proven himself to be a good and able cleaner. He is polite and applies himself with enthusiasm to any job given to him.'* Another officer wrote a similar endorsement of the man's work and behaviour on 19 September. The man's records contain very few other entries after these two.

The First Officer told my investigators that the man was very quiet and polite. He had a fairly small circle of friends, mainly the other cleaners, and he would have a laugh and a joke with them. Outside of that group, the First Officer thought that the man had friendly but superficial relationships with most of the other prisoners. The First Officer said the man was the sort of person who would speak to officers if he had concerns. For instance, he told officers that he was worried about going to North Sea Camp before he was sent there. The First Officer understood that the

man had had a relationship with the girlfriend of a prisoner at North Sea Camp, and that had led to him being assaulted when he went there. The First Officer knew that the man was fearful of prisoners in B and C wings at Lincoln, but he was unaware of the background to these fears. The First Officer said that he never noticed anything about the man's demeanour to give him any cause for concern for his safety.

In his interview, the Second Officer described the man in similar terms. The Second Officer said that the man kept himself to himself. He 'gave away' nothing about his feelings and whether he had any troubles. The Second Officer said that although the man did not say a lot, he would speak when he needed something. The Second Officer confirmed that the man was a good worker who got on well with the other cleaners. The Second Officer said that he would exchange banter with the man about him lifting two mattresses at a time. Like the other officers, the Second Officer was very shocked that the man had apparently taken his own life.

In his interview, the Third Officer said that the man was a man who kept himself to himself, a man who never spoke about having any worries. The Third Officer described the man as someone who got on with other prisoners and who did not bother staff with issues unless he needed something. The Third Officer said that the man came across as not caring what other people thought. He was a big chap who would be able to 'hold his own' if necessary. As with his fellow officers, the Third Officer never had any fears for the man's safety. Similar evidence was given by the Fourth Officer.

The Senior Officer (SO) told the investigators that he had only known the man from the time of his return to Lincoln after he had been in North Sea Camp. Even from that brief contact, the SO described the man as one of the best behaved prisoners he had encountered.

Another SO also referred to the man keeping himself to himself, adding that neither he nor any of the other officers ever had any concerns for the man's safety. After the man's death, the other cleaners told him that the night before he died the man had been laughing and joking with them.

The man's records show that he was issued with a written warning on 9 November for blocking his window with a jumper. The Officer Support Grade (OSG) who issued the warning told the investigators that what the man had done was something that is common practice among prisoners at Lincoln – he had tied his jumper to his cell window to form a makeshift curtain. The OSG said this is forbidden as it prevents night staff from seeing whether or not the window bars have been tampered with. The OSG said that he had first spoken to the man about blocking his window on the evening of 7 November. He told the man to remove the jumper and the man said that he would do so. When the OSG carried out his morning check at 5.30am on 8 November, the man's jumper was still blocking the window. The OSG said that he would not wake a prisoner in those circumstances, but would inform the on-coming day staff about the incident. On the evening of 8 November, the OSG found that the man had again blocked his window with his jumper. The OSG once more asked the man to remove the jumper and the man again said that he would do so. The jumper was still in the same position on the morning of 9 November and it was then that the OSG filled out the warning form. The OSG said that a single warning of this type

would not have resulted in any punishment – a prisoner will only suffer loss of privileges if they have received three such warnings within a three month period. The OSG said that the man had not been argumentative on the evenings of 7 and 8 November. He agreed each time that he would remove his jumper and had been unperturbed about it.

The man's cousin was also in E wing in Lincoln at the time. The cousin said that he and the man were good mates. They last saw each other on the night of Thursday 9 November and they had had a great laugh. The cousin said that there was nothing to suggest that the man was becoming despondent and he carried on with his usual activities like going to the gym. The cousin added, though, that the man never spoke about his real 'feelings' and he never spoke about his girlfriend. The cousin said that the man had been battling to get off drugs for a long time. He would go through detoxification each time he came into prison, but would start using again when out resulting in further crimes. The cousin also said that the man was becoming institutionalised and was effectively homeless when out of prison. The cousin added that both the prisoners and the staff in E wing are nice people.

The day of the man's death

The SO said that at about 10.30am on Friday 10 November, the man approached him to ask if he was due to have a visit that afternoon. The SO telephoned the visits unit and was told that no visit had been booked. The SO said that, when he told the man he was not due a visit, he did not seem concerned.

The computerised telephone records show that between 10.05am and 11.05am that morning the man made four attempts to contact his girlfriend on her mobile telephone. She did not answer any of the calls.

The Second Officer also had a conversation with the man about visits. At around 11.30am, the man asked if any visits had been booked for him for the weekend. When the Second Officer checked, he found that the weekend visits list was not yet available. The Second Officer told the man that the weekend visits list would be available that evening. The Second Officer said that the man seemed fine. That was the last time the two of them spoke. The Second Officer's shift finished at 12.30pm.

The Third Officer recalled speaking with the man that morning. The man was sitting at the servery talking with another prisoner. The Third Officer asked them to move away from the servery and to continue their conversation on the landing. The Third Officer said that the man appeared his usual self.

Another of the prisoners at Lincoln knew the man from going to the gym. He said that the only time the man ever missed going to the gym was when he was aching from the previous day. The prisoner said that he last saw the man at about 11.30am on 10 November. As the prisoner does not like prison food, the man asked him for his sausage roll. The prisoner gave it to him and the man smiled and said thanks. The prisoner said that the man seemed fine. The prisoner also told the investigators that the man did not seem the sort of person who would take his own life.

The First Officer said that just after 12.00 noon he was helping to lock up prisoners after lunch. He asked the man if he had finished his lunch and the man said that he had[2]. The First Officer said *'see you later'* and the man replied, *'thank you very much … see you later.'*

The discovery of the man's death

At about 1.40pm, the Fourth Officer began helping to unlock prisoners for the afternoon. When the Fourth Officer reached the man's cell (on the 4's landing), he saw him hanging from a ligature tied to the cell window. The Fourth Officer shouted to an officer who was across the landing and asked him to call a Code One alarm (a Code One alarm indicates a medical emergency). The Fourth Officer entered the cell. He held the man around the waist with one arm and used his anti-ligature knife to cut the ligature. The man slid to the floor and the Fourth Officer started to check for a pulse. The Fifth Officer then arrived followed by healthcare staff.

The Fifth Officer said that he was on the 3's landing when he heard the shout of a Code One. The Fifth Officer ran up to the 4's landing to assist. He said that when he arrived, The Fourth Officer had already cut the ligature and the man was on the floor. the Fifth Officer removed some furniture so there would be more room in the cell and then checked the man's neck for a pulse. The Fifth Officer said that he thought he detected a faint pulse. He also thought that the man might have been breathing as there were some mucous bubbles coming from his nose. The Fifth Officer asked the Fourth Officer if he could feel a pulse from the man's wrist but he replied that he was unable to. The Fifth Officer said that he asked another officer to get a nurse, but nurses were already on their way. A nurse then came into the cell and began attempts to try to resuscitate the man.

In a formal statement about her involvement, the Nurse wrote that she was in the E wing treatment room on the 2's landing when a call was made for a nurse. She was told that there was a Code One incident on the 4's landing. The Nurse went to the man's cell taking with her the emergency resuscitation bag. The man was on the floor lying on his side. With the help of one of the officers she turned the man onto his back. The man was not breathing, he had no pulse and he was unresponsive. The Nurse gave the man two emergency breathes and checked again for a pulse. The Nurse wrote that other nurses arrived at this point and attempts were made to try to resuscitate the man. A defibrillator was attached but it indicated that no shock should be given. The nurses continued in their efforts to try to resuscitate the man until ambulance paramedics arrived (ambulance service records show that they reached the man at 2.00pm). Unfortunately, all attempts to try to resuscitate the man proved unsuccessful and he was pronounced dead at 2.17pm.

[2] During the post mortem examination the man's stomach was found to contain a large amount of semi-digested food from having taken a recent meal.

Events following the man's death

Family and staff support

Lincoln's family liaison officer (FLO) told my investigator that because of a situation that had arisen following a previous death in custody, Lincoln asked the police for a risk assessment of the man's next-of-kin (his father). It was almost 5.00pm before the police contacted Lincoln to say that there was nothing to indicate that there would be any problems with visiting the man's father. Due to the time it would then have taken to travel to the father's home in Mansfield, Lincoln's FLO contacted Nottingham prison to ask if their staff could make the visit to break the news of the man's death. Unfortunately, Nottingham's FLO had already gone home so Lincoln asked Nottingham police to break the news and to ask the father to telephone Lincoln. The father did so and he spoke that evening both with Lincoln's FLO and with Lincoln's acting Governor. Arrangements were made for the father to visit Lincoln the following day along with his mother (the man's grandmother). The family was able to visit the cell and to speak to staff.

Lincoln paid the man's funeral expenses and Lincoln's FLO and acting Governor attended the funeral. Lincoln sent flowers for the funeral and the prisoners at Lincoln also contributed a wreath after collecting £112.

The vice-chair of the IMB was in Lincoln at the time of the man's death. She spent several hours that afternoon speaking to staff and she also spoke to the man's cousin. He told her that the man was not the sort of person who would discuss significant personal matters with others.

A staff debrief was held on the afternoon of the man's death and the staff on duty at the time were offered the opportunity to speak to the local care team. Prisoners in E wing were told on an individual basis about the man's death.

The report that the man was at risk from other prisoners

On 12 November, a security information report was completed that a prisoner who worked in reception told staff that he was not surprised at the man's death. The reception prisoner was reported as saying that the man was a 'dead man walking' as there were a number of contracts out on him from various drugs dealers. He also said that another ex-prisoner had 'put a price' on the man for assaulting his girlfriend.

The reception prisoner told my investigators that he had known the man for around 15 years. He said that in the last six years the man had begun to take a lot of drugs, and he was committing a lot of crime when on the outside to fund his habit. The reception prisoner said that many of the man's victims had prisoner friends in Lincoln and that was why the man was in E wing. He said that he had also heard a rumour that the man had assaulted the girlfriend of another prisoner and that he was also aiming to get back at him. The reception prisoner said that these people would have waited for the man to come out of prison before doing anything.

The last time that the reception prisoner saw the man was about a week before his death when he was putting some property into storage. The man seemed fine and did not say anything to indicate that he might be thinking of harming himself.

The suggestion that the man told staff that he was feeling suicidal

One of my investigators spoke to the police about their investigation into the man's death. The police investigation included interviews with prisoners. The prisoner who knew the man from the gym told the police that two other prisoners had overheard the man telling staff on the morning of his death that he was feeling suicidal. However, the officers had not taken any action.

My investigators spoke to all three prisoners. The prisoner from the gym said that the man did not seem the sort of person who would have taken his life. However, on the evening of 10 November he overheard two other prisoners talking about what had happened that day. They were saying that they had heard a rumour that the man told staff in the morning that he was depressed but the staff did nothing about it.

The first of the two prisoners told my investigators that he heard a rumour that officers knew that the man was in a depressed mood on 10 November but they had not taken any action. This prisoner did not know the source of the rumour. He said that he did not know how much truth there was in the rumour, but his experience of officers in E wing was that if they have any inkling that a prisoner might be at risk of self-harm, they take appropriate action without delay. This prisoner added that he knew the man from inside and outside of prison and it was totally out of character for him to harm himself.

The second of the two prisoners said that although he had sold cigarettes to the man, they did not really know one another. On the evening of the man's death, prisoners were talking about the fact that he was seen using the telephone in the morning.

MAIN FINDINGS FROM CLINICAL REVIEW

- The man had the standard reception screening for a prisoner transferred from another prison. He did not have a secondary screen as this is only completed for new prisoners. The man was assessed regularly in his first few days as he was on the detoxification regime. The screening process identified that he had substance misuse problems. There was nothing to suggest a risk of self harm.

- Drug detoxification is a potentially risky treatment. I was impressed with the degree of monitoring of the man while undergoing detoxification at Lincoln in August 2006. The nursing care plan meticulously documents what needed to be done and the nursing notes record that he was assessed very carefully.

- The man had significant knee pain and a history of a serious knee injury. He was X-rayed on 23 August 2006. His notes record that the X-ray was chased in September and November, but there is no entry in his notes of the result. The decision to carry out an X-ray should never be taken lightly, and in this case there was clear justification for the test. However, no action was taken because the result was unknown. There should always be a clear trail from investigation, to result, to action.

- The man was at high risk of contracting Hepatitis B and was correctly commenced on a course of Hepatitis B vaccinations. However, he was given the third dose too soon after the second and this might have reduced the vaccine efficacy. Nursing staff said that at times of staff shortages as was apparently the case in the latter part of 2006, Hepatitis B vaccination is accorded a low priority. I was informed that additional staff have recently been trained to give this vaccination and that vaccination now conforms more to the recommended schedule.

- The man's risk of self harm/suicide was assessed on transfer to Lincoln on 11 August. At the reception medical he denied any past history of self harming and he answered "no" when asked if he considered harming himself. A nurse who knew him from a previous period of imprisonment, and spoke to him regularly during this sentence, told me she was shocked that he had killed himself as he had given no indication to her at any time of any distress or desire to self harm.

- All three nurses who attempted to resuscitate the man were of the opinion that he had been dead for some time before his body was discovered and there was no sign of life at any stage during the resuscitation attempt. All three had received training in CPR, and all equipment was in working order. I was satisfied that resuscitation would not have been successful.

- Although there was an immediate debrief following the man's death, none of the three nurses directly involved in trying to resuscitate the man received ongoing support or counselling.

I recommend that a protocol be developed to ensure that healthcare staff are offered ongoing appropriate support following a significant untoward incident.

CONCLUSIONS

The man had become accustomed to serving periodic sentences in prison custody. His final period in custody commenced on 6 June 2006. He spent his first week at Nottingham before being transferred to Lincoln. On arriving in Lincoln, the man asked to be located into the vulnerable prisoners' wing (E wing) as he was concerned for his own safety. It seems likely his concerns were mainly about other prisoners in Lincoln with friends who were victims of crimes he had committed.

Having spent six weeks in Lincoln, the man was transferred to open conditions. While in the reception area of North Sea Camp, the man was struck in the face by another prisoner. He was in North Sea Camp for just two days before he absconded but remained at liberty for just a week. He was re-arrested on 11 August and taken back to Lincoln. On returning to Lincoln, the man again asked to be located on E wing for his own protection.

The fact that the man had absconded from North Sea Camp did not prevent him from obtaining a job as a wing cleaner and he proved to be a good worker. This is both what officers said when interviewed and is reflected in entries made in his records. He was recommended for enhanced status on 15 September and that was approved soon afterwards.

Beyond the fact that the man asked to be located in E wing for his own protection, his records at Lincoln contain nothing to indicate other concerns. Apart from his work as a wing cleaner, the man's main interest was the prison gym and he was a physically powerful man who was neither timid nor frightened. Although the man was said to have had fairly superficial relationships with most prisoners, he apparently got on well with the other cleaners, and his cousin was in E wing at the same time. The cousin said that he was laughing and joking with the man on 9 November, the evening before his death. The cousin also said that the man was not the sort of person to speak about his deeper feelings.

In hindsight, it is possible to look upon events that occurred on the morning of 10 November as indicating that the man might have been anxious about his girlfriend. At about 10.30am, he asked the SO whether he was due a visit that afternoon. After checking with the visits unit, the SO told the man that no visit was booked. At about 11.30am, the man asked the Second Officer if he had any visits booked for the weekend. The Second Officer checked and then told the man that the weekend visits list would not be available until the evening. Although the man did not mention to either officer who he was hoping might visit, we know that from 10.05am to 11.05am he rang his girlfriend's mobile telephone four times but she did not answer.

Neither the SO nor the Second Officer thought that the man seemed concerned when they spoke to him. Two other officers spoke to the man that morning, including the First Officer who locked the man into his cell after lunch. All four officers thought that the man seemed his usual self. That view was shared by the prisoner who knew the man from the gym. He said that the man asked him for his sausage roll at about 11.30am. The prisoner gave the sausage roll to the man who thanked him and smiled.

When the man's cell was unlocked after lunch he was discovered hanging from a ligature tied to the window frame. Staff responded and attempted resuscitation. Unfortunately, all attempts proved unsuccessful and the man was pronounced dead at 2.17pm. The clinical reviewer interviewed the three nurses who were involved in the attempts to try to resuscitate the man. All three thought that by the time he was found, he had been dead for some time.

Following the man's death, the reception prisoner reported to an officer that he was not surprised at what had happened, describing the man as a 'dead man walking'. The reception prisoner told my investigators that there were a number of people who were aiming to get the man because of things he had done in the past. The reception prisoner added, however, that these people would have waited for the man to come out of prison before trying to get their revenge.

Another issue that was explored by the investigators was a rumour that, on the morning of his death, prisoners overheard the man telling staff that he was feeling depressed. The investigators spoke to the three prisoners who potentially knew most about the rumour. None of them personally witnessed the supposed incident and none could give a lead about anyone else who might have done. Moreover, as already mentioned, my investigators interviewed four officers and a prisoner who spoke with the man that morning. All said that the man seemed his usual self.

As is often the case in deaths I investigate, I have been unable to identify any obvious trigger for what occurred. The man gave no clues that might have alerted staff or other prisoners to the possibility that he was at risk, and nor did he leave behind a note of explanation. Everyone to whom my investigators spoke, including the man's father and his cousin, consistently expressed their surprise that the man should take his own life. The man's father told my staff that he had closely studied his son's letters searching for clues, but had found nothing.

Whilst not having any direct bearing on the outcome, I am making one recommendation concerning staff support and two housekeeping points to improve healthcare services for prisoners. Finally, I should report that I consider that the manner in which other prisoners in E wing were told of the man's death is an example of good practice.

RECOMMENDATION

1. I recommend that the prison health partnership should develop a protocol to ensure that healthcare staff are offered ongoing appropriate support following a significant untoward incident.

> *The Prison Service has accepted this recommendation saying: Support is available (to staff) from a range of sources through both the prison and the PCT. A comprehensive protocol needs to be in place to ensure that staff are aware of the services on offer and how to access which service best suits their individual needs. The Prison Service set a target date of August 2007 for completion.*

GOOD PRACTICE

1. It is commendable that the other prisoners in E wing were told of the man's death on an individual basis.

HOUSEKEEPING

The following two housekeeping issues were identified by the clinical reviewer and I urge the prison health partnership to address them:

1. The Head of Healthcare should review the process for ensuring that investigations such as X-rays and blood tests, ordered by medical and nursing staff are actually carried out. The process must ensure that the results are read by the clinician who requested them, recorded appropriately, and actioned.

> *The Prison Service has accepted this recommendation saying: A review of current practice with regard to the follow up of investigations will be carried out and the local protocol developed.*

2. The Head of Healthcare should review the process of ensuring that all patients at high risk are offered Hepatitis B vaccination, and that the correct ("Green Book") schedule is followed.

> *The Prison Service has accepted this recommendation saying: A rolling programme of training is now in progress. Since the death of Mr Roberts, a nurse manager is now in post and responsible for the Hep B vaccination programme.*