INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF A MAN IN JUNE 2007 AT HMP HOLME HOUSE

Report by the Prisons and Probation Ombudsman for England and Wales

February 2008

This is the report of an investigation into the death of a man who was found hanging in his cell at HMP Holme House on 27 June 2007. He had been in custody for eight months. I would like to extend my sincere condolences to his family and friends for their loss.

Three months before his death, the man had been sentenced to life imprisonment at the Crown Court on 26 March 2007. The judge recommended that he serve no less then 13 years in prison. The man had served previous custodial sentences and had apparently anticipated a longer minimum term to his life sentence.

One of my investigators conducted this investigation. The North Tees Primary Care Trust also conducted a clinical review into the man's care and treatment whilst at Holme House. I would like to thank the Governor of Holme House, and his staff for their help and active co-operation during this investigation. I am also grateful to the Cleveland Police for their ready assistance.

The man's sisters have been in contact with both Holme House and my investigator from an early stage. A key part of the investigation was to ensure that they had the opportunity to raise any concerns. My investigator and one of my family liaison officers met the man's sisters and their partners on 4 September 2007. In this report we have done all we can to answer their questions.

The man had a history of alcohol misuse. According to his family, he had made three attempts on his life in the year before his arrest. He had been on a constant watch while in police custody, and acknowledged on reception to Holme House that he had taken a drugs overdose two months earlier. However, during his time in custody, the man had not given staff or fellow prisoners any cause for concern. At the time of his death, a note he had written was found in which he had outlined his intentions. He had also written that the prison and its staff had been good to him.

The death of this man was the first of two apparently self inflicted deaths at Holme House within days of each other. I am satisfied that the deaths were not linked. I am also satisfied that the man did not share with staff or prisoners any indication that he intended to take his own life.

This report has been anonymised for publication on the PPO website.

Stephen Shaw CBE
Prisons and Probation Ombudsman **February 2008**

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SUMMARY

The man was 40 years old when he was received into HMP Holme House in October 2006 as a remand prisoner charged with murder. He had been to prison previously, and had a history of alcohol misuse from the age of 16. The prison was notified that he was at risk of suicide and self harm. A Cell Sharing Risk Assessment (CSRA) was completed and he was deemed suitable for sharing a cell. He told staff that he had no thoughts of self harming or suicide. He was initially located in the healthcare centre for increased observation and assessment.

The man was then moved to Houseblock three, C wing, where he settled into the regime very quickly and shared a cell. In December 2006, he asked for a single cell and, owing to his good behaviour, this request was granted. He regularly attended art classes and Catholic services. He was well known and liked by the Roman Catholic chaplain, and regularly attended Mass.

In March 2007, the man was sentenced at Crown Court to life imprisonment. He was to serve a minimum custodial period of 13 years. Subsequently at Holme House he was interviewed as part of the post conviction immediate needs assessment. He told staff that he had expected a life sentence if found guilty and had expected a higher tariff. He said that he never thought about self harming whilst in prison and that he did not require additional help. He was moved to Houseblock six for convicted prisoners where he quickly settled, meeting prisoners whom he had known from outside prison. It was recorded in his core record that he was never a problem or concern. He kept his cell spotless, and displayed a good attitude to both prisoners and staff. The Catholic chaplain described him as a very helpful and kind person.

On 26 June 2007, he was locked in his cell for the night at 7.30pm. He was not on any special self harm/suicide support or monitoring arrangements. At 5.50am on 27 June, during the early morning roll check, the man was discovered by night duty staff. He had placed paper across the observation panel in the door and was found hanging by a ligature made from his bed sheet that was attached to his window in his single cell. The staff cut the ligature and lowered him to the floor. They immediately formed the view that he had died and therefore no attempt was made at resuscitation. He had left a handwritten a note in which he outlined his intention to take his own life. He laid no blame for his death with anybody else.

A post mortem examination found that the man had died as a result of hanging. There was no evidence to suggest third party involvement.

This report makes one recommendation regarding the obtaining of prisoners' previous medical records.

THE INVESTIGATION PROCESS

1. The investigation was formally opened at Holme House on 2 July 2007 by one of my investigators. The Deputy Governor and her staff produced the man's core record and a number of other documents for examination. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone with relevant information to make themselves known to my investigator. My investigator was given unrestricted access to the prison, staff and documentation relating to the man who died. My investigator was also able to speak with Cleveland Police in relation to issues of common interest.

2. The North Tees Primary Care Trust conducted a clinical review of the man's care and treatment. A representative from the Trust also took the opportunity of visiting Holme House.

3. My investigator and a family liaison officer (FLO) from my office met the man's sisters and partners. My investigation has attempted to answer the questions posed by his family:

    - What was the estimated time of his death?

    - The man had tried to commit suicide three times in the year before he went to prison. The family would like the investigation to establish what was known by the prison about his past medical history. The family believe that, if the prison had known about his history, he would have been located in a safer cell.

    - What was the man wearing when he was found?

    - The man told his family he was being transferred to HMP Frankland. The family would like the investigation to establish if this was true, and if so, when he was told and whether he had a date for the transfer. This may have caused him some concern.

    - Whether there were any other marks or injuries to his body?

    - The family raised the concern that the prisoner in the cell opposite had called the man's mother to inform her of her son's death before his sisters had been informed.

    - Letters were missing from the man's possessions, including one sent on the Friday before his death. I was asked to try to establish where they were.

    - Whether the man had any counselling in prison as the psychiatric report prepared for his trial highlighted that he needed this support?

    - Where the money in his account had come from?

- Whether the man had been subject of bullying?

- The family retrieved the contents of the man's cell bin in which were parts of some letters that had been ripped up. The family asked the investigation to establish where the missing parts were.

- During the family's last visit to him on the Thursday night, he had been excited as he was expecting to have an inter-prison visit with his son. The family asked whether his son's mother could have prevented the visit.

- The man had sat an art examination and the family want to know whether his results were known.

- The man had been a keen artist and one of his paintings had recently been entered into a competition. The family would like that painting returned if possible.

4. Some friends of the man, Mr A and Mrs B, wrote to my investigator. They said that the man's letters were optimistic until his son was imprisoned, although the prospect of an inter-prison visit had cheered him. They posed the following questions.

    - Whether the man was prescribed medication?

    - What psychiatric support was provided for him?

    - Whether he was on a 'suicide watch'?

    - Did he mix with other prisoners?

    - Was he being seen by the Listeners?

    Mr A was critical of Holme House in his correspondence with my investigator,

5. Whilst formally opening the investigation at Holme House, my investigator was informed of a magazine called 'That's Life' dated 28 June 2007. The magazine carried an article which referred to the man who died. The article had been given to the duty governor by a member of Holme House staff after learning of the man's death.

6. Prisoners and staff were interviewed and those interviews tape-recorded. The interviewees were asked to sign and return the transcripts.

7. My investigators wrote to HM Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death.

HMP Holme House

8. Holme House is a category B prison for adult males, opened in May 1992. The prison primarily serves the communities of the Tees Valley, South West Durham, East Durham and North Yorkshire.

9. The prison has an operational capacity of 994 prisoners. There are six Houseblocks, and a purpose built healthcare unit with 26 inpatient beds.

10. In common with other prisons, Holme House runs an electronic pegging system for night duty staff. The staff are issued with an electronic wand which they pass over a pre-determined pegging point on their wing. This records the movement of the staff.

11. After a period in healthcare, the man was moved as a remand prisoner to Houseblock three which is a vulnerable prisoners/induction and first night centre for 183 prisoners. He was then moved to Houseblock four which is also for vulnerable prisoners and has a drug dependency unit (again accommodating 183 prisoners in total). Upon conviction, the man was moved to Houseblock six which accommodates 132 prisoners.

Suicide and self harm monitoring

12. The Assessment, Care in Custody and Teamwork (ACCT) process has been introduced at HMP Holme House to monitor and support prisoners assessed as at risk of suicide or self harm. (The previous system was known as the F2052SH procedure.) Once placed on ACCT, the prisoner is observed at pre-determined intervals, according to the perceived level of risk.

13. Each prisoner is assessed within 24 hours and then reviewed at intervals decided on an individual basis. The ACCT guidance says that, to be effective, the review should involve the key people who know the person at risk or are involved in their care. The key questions for each review are listed as:

    - Have the problems that caused the ACCT plan to be opened now been resolved?
    - If not, what needs to be done to resolve them?
    - Have any further problems arisen that are now causing distress and more risk?
    - If so, what action can be taken to address these?
    - Is the person at risk now in contact with friends, family or other support?
    - Does the person at risk now have something in their lives that they feel good about?
    - If not, how can this be improved?

    Over time, the reviews should also consider other factors such as:

- Distress – has anything changed to make the person at risk more or less desperate?
- Resources – has anything changed that makes the person at risk now feel more or less alone?
- Previous suicidal behaviour – has anything changed that makes suicide more familiar or more acceptable to the person at risk?
- Suicide intention or plan – has anything changed to show that the person at risk is more or less prepared to kill themselves?
- Pattern of self harm – is self harm becoming more or less frequent?

14. Amongst other things, the ACCT guidance states that prisoners should be cared for in a safe environment and that it is for the Case Review team to decide the most appropriate place to locate an individual prisoner. The man was not identified as a prisoner at risk of self harm and was therefore not subject to self harm monitoring or support.

Listeners

15. Listeners are prisoners trained by the Samaritans to offer confidential support for prisoners in distress. The Listener scheme has been running for eight years at Holme House. In addition, prisoners have confidential access to Samaritan phones for extra support in times of distress. There is no evidence to suggest that the man ever used the Listener facilities.

Previous deaths at Holme House

16. The man's death was the fifth apparently self inflicted death to have occurred at Holme House since April 2004 when I became responsible for all investigations into deaths in prison custody. Sadly, another apparently self inflicted death occurred in another part of the prison during the summer of 2007. The prisoner concerned died in hospital on 1 July. I judge the circumstances to be entirely unrelated.

HM Chief Inspector of Prisons' inspection

17. HM Chief Inspector of Prisons conducted a full announced inspection of Holme House between 11-15 April 2005. In her subsequent report (published in September 2005), the Chief Inspector said she and her team had found Holme House to be a largely safe and well-ordered establishment. Suicide and self-harm prevention was judged to be well managed, and the Chief Inspector reported that many of the prisoners most likely to be at risk of self-harm were diverted to beds in the healthcare centre upon reception.

18. The Chief Inspector said there was a good range of clinical services delivered by a well qualified, experienced and committed healthcare team. Prisoners had good access to primary care through the introduction of wing based surgeries and the attendance of visiting health professionals. In addition, inpatients were well cared for in a therapeutic environment and were encouraged to participate in the available regime. She said that joint work with North Tees NHS Primary Care Trust was underpinned by strong leadership

from both organisations, and there had been a successful transfer of the commissioning of healthcare to the PCT in April 2005.

19. The Inspectorate reported that Holme House provides 24 hour nursing care for prisoners. Two full time medical officers, one of whom was a general practitioner (GP), were employed full time at the prison by the PCT. Out of hours medical cover was provided by a local GP practice.

20. HM Chief Inspector of Prisons found that healthcare staff had a strong team ethos and demonstrated an enthusiastic and professional approach to the care of patients. A trained nurse saw all new prisoners in reception to complete a health screening and a well man assessment. Prisoners identified with a problem or chronic illness, such as asthma or diabetes, were noted on a chronic disease register and followed up by the Houseblock or other specialists, such as the CARATs (counselling, assessment, referral, advice and throughcare) drugs service.

21. HM Chief Inspector of Prisons said that any prisoner on a long sentence who appeared to be coping poorly was offered a bed in healthcare for a period of assessment. Prisoners who needed alcohol or drug detoxification were also offered a bed in healthcare. Some refused this option and went straight to the Houseblocks. Prisoners could see the doctor in reception or in healthcare if they wished. All those with a serious medical condition saw the doctor within 24 hours.

KEY EVENTS

Events prior to 27 June 2007

22. In October 2006, the man was arrested and charged with murder. He appeared at Magistrates' Court late in October and was remanded in custody. The duty probation officer sent a fax to Holme House at 1.25pm informing the prison that information had been given to the court that the man had threatened to commit suicide. A prisoner escort record (PER) form was correctly completed and warned that he was an alcoholic, charged with murder and had been on a constant police watch.

23. The man was then taken by prison escort contractors to Holme House. A cell sharing risk assessment (CSRA) was completed and he was located in the healthcare centre for closer observation and assessment. A Suicide Self Harm Warning Form was also completed, although he told staff that he had no intention of committing either self harm or suicide. He was also seen by a registered medical nurse and said that he was alcohol dependent, and was allergic to librium and paracetamol. The man also said that he was dependent on diazepam, prescribed to him for alcohol withdrawal. He denied any form of mental illness, but was being treated for alcohol dependence and depression by his own doctor. He said he had taken an overdose two months earlier. He was seen by the prison doctor the following day (24 October), but declined all medication as he said he wanted a clear head.

24. After assessment on 30 October, the man was moved to C wing of Houseblock four, in cell 4C:7. He settled into the wing regime very quickly, and was described as polite and very respectful. On 1 November, a general health assessment was completed. The man believed that he was due a review for bladder surgery that he had had in hospital in September 2006.

25. The man was seen by a nurse in triage on 2, 23 and 30 November and 12 December and, according to the clinical reviewer, was treated appropriately. On 17 December, an entry in his prison history folder reports that he had a good attitude and behaved well. The man asked for a single cell as he was an early riser and was often up and dressed at 8.30am. He attended education art classes. On 22 December, he moved to cell 4C2.2, a single cell, and was again noted to have a positive outlook. He attended triage again on 28 December.

26. The man went to the triage nurse once more on 4 January 2007, and saw the doctor on 15 January. He returned to triage on 8 February, complaining of tenderness to his right arm. He was referred to physiotherapy. He was given medication to aid his sleeping. On 22 February, he attended triage and complained of difficulty sleeping. He was given further medication.

27. The man was awarded enhanced status under the prison's Incentives and Earned Privileges Scheme on 5 March 2007. This meant he was entitled to extra privileges owing to his good behaviour. He saw the triage nurse again three days later on 8 March. The man said that he was not coping and the

medication was not helping. He was prescribed more medication and seen later that day at 4.45pm. He said that his heart was pounding and that his face was flushed. He was concerned that his medicine might have been causing the symptoms. He was advised to stop taking it, but he returned to triage a week later on 15 March to request repeat medication which was prescribed.

28. The man was seen for a Mental Health Assessment on 17 March. In late March, he was found guilty at Crown Court and sentenced to life imprisonment with a recommended minimum tariff of 13 years. He was returned to Holme House. A note in his medical records shows that he was seen by healthcare staff and denied any thoughts of self harm or suicide.

29. The man was seen in triage on 5 April when he requested medication for previous liver problems. He also complained of a fast heart beat. Arrangements were made for him to have an electrocardiogram (ECG) (a machine that measures the electrical output of the heart). He had an ECG on 6 April and was further seen in triage on 10, 12 and 17 April.

30. The reception officer and the duty officer interviewed the man on 18 April and filled out the Post Conviction Immediate Needs Assessment form. The reception officer recorded that the man had been expecting a life sentence, but with a higher tariff. The man said he had not thought about self harming whilst in prison, and did not require any additional help. He attended triage on 24 April and declined to see the doctor on 26 April, although he saw him on 1 May. He was seen by the Mental Health Team on 4, 17, 18, and 31 May and was seen by healthcare staff on 17, 24, and 31 May.

31. As the man was now a convicted prisoner, he was moved onto B wing of Houseblock six on 4 June. Two days later, he made a telephone call to his son who was at a Young Offenders Institution. The last entry in the man's personal history folder on 15 June recorded that he had no concerns or issues and was polite and helpful to staff.

32. The man was seen in triage on 21 June. He complained of numbness, and pins and needles in his feet. He was referred to the doctor who saw him on 26 June. The doctor recorded that the man had peripheral neuropathy (loss of sensation in his legs) for which he was prescribed medication.

33. The man was well known to the prison's Roman Catholic chaplain. The chaplain said that the man was helpful and took his religion seriously. He described him as very considerate to others, and nothing seemed too much trouble to him. He used to willingly make tea and wash up after Mass. The chaplain last saw him at Mass on Friday 22 June when the man gave him a prayer card. The chaplain asked him if he was okay and the man said, 'I am okay, I was asked that question earlier by somebody else and I answered by saying I have found God I must be alright.' There was nothing in the man's demeanour to give the chaplain any cause for concern.

34. A prisoner in Houseblock six knew the man outside prison. He said that the man was a good artist, and described him as a happy person. They would often chat over tea in each other's cells. The prisoner said that the man was a very clean and tidy person and his cell was always immaculate. On the evening of 26 June, the man asked him for some tobacco and he gave him some cigarettes.

35. Another life sentenced prisoner at Holme House had known the man for over twenty years. They met again in prison and shared adjoining cells for several weeks before the man's death. He described the man as happy-go-lucky and said that he used to joke about hanging himself. On the morning of 26 June, the man had seen the doctor with a complaint about his feet and he discussed his visit with the prisoner. The man also mentioned that he had sent £50 to his son and was concerned whether he had received the money. My investigator has established that the money was placed in his son's account on 29 June 2007.

36. At approximately 7.20pm on 26 June, the second prisoner was the last person whom the man spoke to before they were locked in their respective cells. The man also asked the second prisoner for an ounce of tobacco and he gave him enough to make two or three cigarettes. They exchanged pleasantries and said they would see each other in the morning. (They had an agreement that whoever woke first would knock on the adjoining wall and the other would respond with a knock.)

37. The wing officer works on Houseblock six. In interview, he said he knew the man as a quiet individual who only asked questions of staff when he needed to. On the evening of 26 June, the wing officer locked the man and other prisoners in their cells at approximately 7.30pm. The wing officer does not recall anything unusual about him. The officer counted all the prisoners on his wing to check the roll before going off duty. He had no further contact with the man.

38. An operational support grade (OSG) at Holme House started her night duty on Houseblock six at 7.45pm on 26 June as the sole night patrol officer. She received a briefing from the outgoing officer. In interview, she recalled that there were no prisoners to be monitored on self harm watches, and she checked all the cells for her night roll check. She was not required to check the prisoners again until the morning roll, unless anyone activated their cell bell to request assistance. From electronic records my investigator established that the man did not activate his cell bell during the night.

Events of 27 June 2007

39. The second prisoner woke up on 27 June at 4.45am and knocked on the man's wall as usual. Unusually the man did not respond. At approximately 5.25am, the prisoner looked through the gap in his cell door and saw the night duty officer doing her early morning roll check checking each individual cell. He then heard her kicking a cell door and officers running to the man's cell.

40. At 5.50am, the OSG carried out the morning roll check of all the prisoners in Houseblock six. On checking the man's cell (B2:21), she saw that his observation panel had been covered from the inside. She banged on the door but did not receive a response. She went straight to the centre office and telephoned the Night Orderly Officer (the senior officer in charge of the establishment). The orderly officer, together with the second and third wing officers and the duty nurse immediately went to the man's cell.

41. At 5.55am, the orderly officer opened the cell door. He saw the man hanging at the rear of the cell with a ligature made from his bed sheet tied around his neck. The other end of the ligature was attached to the window. The man was faced towards the officers dressed in prison issue clothing of a maroon tee shirt, jeans and socks. Because the man was discoloured and cold to the touch, the orderly officer thought that he was already dead. He cut the ligature between the window and the man's neck with an anti-ligature knife, and lowered him to the floor. The orderly officer then radioed the control room for an ambulance. The second wing officer cut the ligature from the man's neck.

42. The duty nurse has 31 years' nursing experience. She noticed that the ligature was deeply embedded in the man's neck, and his skin had swollen over the top. The man was stiff and cold to touch, with obvious signs of settling of blood in the lower parts of his limbs. The duty nurse decided that resuscitation was inappropriate as she believed that the man had died. Upon their arrival at 06.25am, the ambulance crew and the prison's medical officer confirmed the man's death.

43. The orderly officer found a handwritten note left in the cell by the man. The note outlined his intentions but laid no blame on anyone else for his actions. The orderly officer placed the note and the ligature in an exhibits bag that was subsequently handed to the police. The police have concluded that there was no third party involvement in the man's death.

44. The second prisoner saw the activity outside his cell and was told that the man had been found hanging. He said the man had given him no indication that he intended to take his life and he had expected to see him that morning as usual.

45. The police were called and attended the man's cell, taking photographs and seizing exhibits. It is known that, after the police formally released the cell to the prison, the family found parts of a letter that had been torn up with several pieces missing.

46. The Catholic chaplain was in the prison that day, and was shocked to learn of the man's death. He too had seen no indication of his intentions. My investigator asked the Catholic chaplain what the relationships were like between staff and prisoners. The chaplain was also asked if he thought the man would have been confident to have sought help from staff if he was troubled by anything. The Catholic chaplain said that staff-prisoner

relationships were very good, and that the man was a mature prisoner who understood life within a prison setting.

47. When the first wing officer came on duty at 7.30am, he too was surprised to hear of the man's death. In interview, he also said that the man did not give anyone cause for concern.

48. A hot debrief of staff took place after the discovery of the man who died and it was concluded that the contingency plans had worked well. Prisoners were offered the support of Listeners and the chaplaincy. The staff care and welfare team offered support and comfort to staff.

Post mortem

49. A post mortem was conducted on 27 June 2007 by a pathologist. He gave the cause of the man's death as hanging. The doctor commented that, apart from the ligature mark, there were no other recent injuries present on the man's body. His findings were entirely consistent with self suspension. He could find nothing to indicate the involvement of any other person in the man's death. There was no pre-existing natural disease to contribute in any way. I understand that the toxicology results have not given the Coroner cause for concern.

Contact with the man's family

50. A senior officer (SO) acted as the prison's family liaison officer, keeping a log of her contact with the man's relatives. The SO together with the governor personally broke the sad news to one of the man's sisters.

51. The SO has remained in contact with the man's family and offered financial support for the funeral arrangements. She attended his funeral with the Roman Catholic chaplain and other members of staff. She has also arranged for the man's art work to be returned to his family, together with an educational certificate in art awarded after his death.

52. I am pleased to record that the man's sisters have been satisfied with the level of cooperation they have received from the prison and the prison's family liaison officer. Family members have had the opportunity of visiting the prison after the man's death. I would also like to add my personal thanks to the SO for the care and support she has shown to the man's family.

Staff and prisoner welfare

53. After the man was discovered, staff held a hot debrief. It was judged that the contingency plans had worked well, allowing the ambulance unrestricted access to the prison. Arrangements were made for prisoners to see Listeners if they wished.

54. Staff and prisoners interviewed for this investigation felt generally well supported.

ISSUES CONSIDERED IN THE INVESTIGATION

Clinical care

55. The clinical review found that the initial screening documentation was complete. The Risk Assessment checklist had been carried out, and the first and second health screening conducted within timescales and constituted a complete record. The screening process identified the man as receiving diazepam (for depression), zopiclone (for sleep problems), omeprazole daily, vitamin B and thiamine.

56. At reception, the man gave his medical history and told staff of a drugs overdose the previous year when he was under the influence of drugs. He said he had no current thoughts of self harm or suicide. The clinical reviewer could find no evidence that his previous medical records had been requested, although a psychiatric report prepared by the court was contained within his prison records.

    The head of healthcare should routinely seek the previous medical records of prisoners upon their initial reception.

57. The man was admitted from reception into the healthcare unit for observations and assessment of alcohol misuse. He denied suicidal intention but stated he had taken an overdose two months previously whilst under the influence of alcohol. He had a diagnosis of mental illness and was appropriately referred to the Mental Health Assessment Service on admission, and was assessed on 17 March. Following this assessment, it is clearly documented that he was seen regularly by the Mental Health Team and a referral to drug counselling was established. A history of suicidal feelings was identified by the man and these were explored and managed appropriately through support from the Mental Health Team. This intervention was correctly documented in the care plan and regularly reviewed.

58. The man's physical health history was also taken and nothing untoward identified, other than a previous secondary care episode of surgery for scar tissue on the bladder. He was due for review on 2 November 2007.

59. A full history of alcohol use was also obtained. He was referred for alcohol support services and detoxification but declined this intervention. He was allergic to alcohol detoxification drugs and was therefore prescribed thiamine.

60. The clinical reviewer has assessed that the care provided was appropriate and comments that the man did not need to be referred to other agencies and therefore no contact was made. The contemporaneous record was complete, dated and signed. The care plan pathway was complete and very clear. There were some occasions when entries into the care record failed to include the printed name and time of intervention, but the standard of record keeping was appropriate to ensure effective communication. (I make no formal recommendation regarding record keeping, but staff should be reminded to sign and date entries in all prison records.)

Family concerns

Transfer plans

61. The man had told his family that he was going to HMP Frankland and they wanted the investigation to establish if this was true. They wanted to know when he was told he was going to transfer, and whether he had a date for it to take place.

62. A governor told my investigator that, when officers were completing the man's Lifer paperwork, he would have been asked where he wanted to transfer to complete his sentence targets. It appears Frankland was one of the prisons discussed as it was easy for his family to travel to. The governor said that the man had not officially been allocated to Frankland and no date had been set for any transfer.

Missing letters

63. The family were concerned that the prisoner in the cell opposite the man had called the man's mother to inform her of his death before his sisters had been told. Whilst I make no formal recommendation, the governor may wish to consider isolating the use of prisoners' telephones until such time as the next of kin have been informed of a death.

64. Letters were missing from the man's possessions, including one sent the Friday before his death. The family wanted the PPO investigation to establish where they are, but unfortunately we have not been able to establish any further information. When the man's family visited his cell after his death, they retrieved the contents of his cell bin in which were parts of some letters that had been ripped up. The family asked the investigation to establish where the missing parts were. My investigator has not been able to identify where the missing parts of the letter are. The cell had been examined and sealed by the police.

Bullying

65. The family wanted to know whether the man had been subject of bullying. Through talking to prisoners and staff who knew him well, my investigator has uncovered no suggestion that he was being bullied or was in debt.

Contact with his son

66. During the last family contact with the man on Thursday 21 June, his family said that he was excited as he expected to have an inter-prison visit with his son. The family asked whether the man's son's mother could have stopped this visit. The governor said that no formal arrangement was in place for an inter-prison visit between the man and his son.

Magazine article dated 28 June 2007

67. My investigator has established that the ‘That’s Life’ magazine that carried an article on the deceased was in circulation prior to his death. However, through talking to prisoners and staff, my investigator has found no evidence that the man was himself aware of the article.

CONCLUSIONS

68. The man was a convicted prisoner at the start of a life sentence with a minimum tariff of 13 years. He had apparently anticipated a longer minimum term.

69. The man had a history of alcohol misuse. According to his family, he had made three attempts on his life in the year before his arrest. He had been on a constant watch while in police custody, and acknowledged on reception to Holme House that he had taken a drugs overdose two months earlier.

70. The eight months he was in custody at Holme House appear to have been unremarkable. Prior to his death, he had been attending education, had recently received a visit from members of his family, and had attended a Catholic Mass. He was described as positive and forward looking. He gave no one any indication of the distress he must have been feeling.

71. At the time of his death, the man was not subject to special self-harm and suicide prevention measures, nor was there any reason for him to be so. He had given no one in the days immediately prior to his death any indication that he might have been at risk of self harm.

72. A letter of the man's intention to end his life was found in his cell at the time of his death. He placed no blame on the prison or upon prison staff.

73. In sad circumstances, the prison appears to have managed its family liaison responsibilities well. Support for staff and other prisoners was also well conducted.

RECOMMENDATION

The head of healthcare should routinely seek the previous medical records of prisoners upon their initial reception.