Investigation into the circumstances surrounding the death of a man at HMP High Down in May 2008

Report by the Prisons and Probation Ombudsman for England and Wales

August 2009

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This is the report of an investigation into the death of a prisoner who was found hanging in his cell at HMP High Down in May 2008. He had been at High Down for less than a month.

I offer my sincere sympathies to the man's partner, family, and friends, and all those affected by his loss. Investigations into the deaths of young people are especially sad. I must apologise for the delay in issuing this report.

The investigation was conducted on my behalf by my colleague. In addition, a clinical review into the care received by the man while he was in prison was undertaken by an Independent Health Clinician for the local Primary Care Trust (PCT). The clinical reviewer was assisted by a Consultant Forensic Psychiatrist. Although the review was somewhat delayed, I am most grateful to both for their contribution. I am also grateful to the Governor and staff of High Down for their assistance during the investigation process.

The man was a young person serving a relatively short prison sentence for witness intimidation. There had been times in his short life when he had experienced depression and paranoia, and he had abused alcohol. He had had previous contact with community mental health services. He also had a history of harming himself and had done so only two days before being taken into prison custody. When he arrived at High Down, he claimed he was taking anti-depressant and anti-psychotic medication.

However, in the brief time the man spent at High Down, he was assessed by mental healthcare staff and was not considered to be at risk of harming himself. Neither did he display any suicidal intentions to staff on his houseblock. Nevertheless, his last day in custody seems to have been a particularly anxious time. He made a number of telephone calls to his partner and family in which he expressed his great unhappiness at having to transfer to the young offender wing at HMP Norwich. There can be no doubt that it was this impending transfer that was the trigger for his actions.

I conclude that the man received a generally good level of care at High Down. I commend those staff who discovered him and who attempted to save his life.

I make four recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman **August 2009**

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SUMMARY

The man arrived at HMP High Down in April 2008, having received an eight month sentence for witness intimidation. He had previously served one custodial sentence. Because of his age, the court's assumption would have been that he would serve his sentence in a young offender institution.

When the man was screened at reception, he said that he was taking both anti-depressant and anti-psychotic medication. He also said that he had been treated by a psychiatrist in the community and diagnosed as having a multiple personality disorder and Attention-Deficit Hyperactivity Disorder (ADHD). He said he had harmed himself in the past, but was unable to supply any details of the most recent episode. He also said that he had previously injured his right hand from punching a wall. Staff did not think that he was suicidal and he denied that he had any intention of hurting himself.

A referral was made for the man to be assessed by the prison's Mental Health In-Reach Team (MHIT). He was assessed by a MHIT psychiatrist as well as a nurse. Information was also obtained from his doctor in the community, who explained that he had been discharged from their care because he did not go to his appointments. Neither the In-Reach nurse nor the psychiatrist believed that he was at risk of harming himself. He was recommended to the "movements psychotherapist" within the prison for further treatment.

On the morning of 13 May, the man was told that he was to be transferred to the young offender wing at HMP Norwich. He made a number of telephone calls that evening to his partner and family informing them of his move, and asking them to contact the prison on his behalf to stop his transfer. As a result of the calls made into the prison, the senior officer on the man's houseblock spoke to him. The senior officer noticed that the man was concerned about being transferred, but did not detect any signs to suggest that he would harm himself.

Later that night, a prisoner in the cell next door to the man pressed his cell bell and asked the Operational Support Grade (OSG) to check on his neighbour. The man was discovered hanging by a ligature made from torn bed sheets tied to the cell window. Despite staff reaching him quickly and carrying out cardio pulmonary resuscitation (CPR), he was pronounced dead at 12.20am (14 May).

From the phone calls that the man made to his family, it is unclear whether he intended to take his own life or wanted to hurt himself to prevent the transfer. A letter addressed to the Governor that was found after his death suggests he chose to take his own life rather than be transferred to Norwich.

My report includes four recommendations.

THE INVESTIGATION PROCESS

1. One of my colleagues was appointed to lead the investigation into the circumstances of the man's death. He opened the investigation on 16 May 2008 when he visited HMP High Down. He met the Governor, Deputy Governor and representatives from the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB). He was shown around the prison by the Deputy Head of Residence, who acted as the liaison point for the investigation.

2. My investigator also liaised with the Police, who conducted their own investigation in relation to the death of the man. The outcome of their inquiries was that there was nothing to indicate that he was indirectly or directly encouraged to take his own life. A copy of the police report was shared with my investigator.

3. The Primary Care Trust (PCT) Quality and Clinical Governance Manager was appointed by the PCT to conduct the clinical review. Although the review was delayed, I thank her for the work she has carried out. I extend those thanks to the Consultant Forensic Psychiatrist, for her input into the clinical review.

4. My colleague issued notices inviting staff and prisoners to contact him with any information they felt might be relevant to the investigation. Interviews were conducted with several staff and one prisoner.

5. One of my Family Liaison Officers, spoke and wrote to the man's partner and his mother, to invite their involvement in the investigation process. Both raised a number of issues and concerns and I hope that my report addresses them properly.

6. Upon receipt of my draft report my investigator and FLO met with the man's parents and grandparents, who raised there concerns that his vulnerability due to his previous and long history of mental health illness was not taken seriously enough by the prison. These views were mirrored by his partner, who wrote to my FLO saying she found it disturbing that in view of the man's mental health history, they took him at his word when he said he had no suicidal thoughts.

HMP HIGH DOWN

7. Situated in Sutton, South-West London, HMP High Down opened in September 1992. It was initially a core local prison (able to take top security category A prisoners) but in 2003 it became a category B prison. It holds approximately 1103 prisoners. Each houseblock has three spurs (A, B and C) and each is broken down into three levels, 1 being the lower level, 2 the middle and 3 the upper level. There is a gate at the end of each spur.

8. Houseblock 3 holds approximately 181 prisoners and is the First Night in Prison and Induction houseblock, generally for new prisoners. They are moved on once they have completed their induction and a space becomes available on one of the other blocks. The only long-term prisoners remaining on the houseblock are cleaners, peer advisors and gym orderlies.

9. The healthcare centre has 23 in-patient beds, all in single cells, supported by 24-hour nursing cover. A range of primary care services is also available for prisoners. Four of the healthcare cells have gates rather than doors to allow staff to observe the patients in those cells more closely. There is a day area where the patients can watch television and relax. A member of the education staff attends the day centre twice a week to provide activities for the men. Having gone through the prison reception process, prisoners at High Down are generally located onto the Induction Wing where facilities and the regime of the prison are explained. After a suitable period on the Induction Wing, they are re-allocated to a regular residential wing.

10. Although High Down does operate a young offender function, due to current prison population pressures, it is also operating as an overflow for young offenders from HM Young Offender Institution (HMYOI) Feltham and HMP Chelmsford. At the time of my investigation, 260 young offenders were held at High Down. As an adult prison, High Down's regime is geared towards offering an adult regime and facilities.

Independent Monitoring Board (IMB)

11. IMB members are appointed to each prison by the Secretary of State for Justice to monitor the treatment of prisoners. They are not members of the Prison Service, nor are they part of the prison's management team. They are required to report annually to the Secretary of State, highlighting good practice and any areas of concern.

12. The IMB report for High Down for the period 2006-07 emphasised the increasing range and mix of prisoners in the establishment, some of whom the Board believed had been inappropriately placed in a local prison. They also commented on the difficulties caused by reduced funding and overcrowding. However, they believed that High Down was well run, with "the vast majority of staff committed to providing a secure, fair and decent regime for prisoners". There had been particular emphasis in building good relationships between staff and prisoners.

Her Majesty's Chief Inspector of Prisons

13. The most recent inspection of High Down by HM Chief Inspector of Prisons, was an announced inspection in May 2006. The Chief Inspector's report of her findings included the following:

    - "High Down, along with all local prisons, is under tremendous pressure as a result of the growth in the prison population. Despite this, the establishment had made considerable strides in a number of areas.

    - "Healthcare services were good in all areas except dentistry, and action to change the dentistry provider had begun. Primary care and GP clinics were delivered on the wings, and nurses were based there throughout the working day. An impressive array of visiting professionals supported these core staff. Mental health services were very good, with a coordinated strategy aimed at providing the best care either in the inpatients' facility or on the wings. The joint working between the in-reach team and the primary mental health team was particularly impressive."

Previous PPO investigations into self-inflicted deaths at High Down

14. Since my office took responsibility for investigating all deaths in prison custody in 2004, there had been four previous apparently self-inflicted deaths in High Down before that of the man who is the subject of this report. None had any similarities to the present investigation.

Assessment, Care in Custody and Teamwork (ACCT)

15. ACCT has been introduced at all prisons to monitor and support prisoners assessed as at risk of suicide or self harm. Once placed on ACCT, the prisoner is observed at intervals determined by their perceived level of risk. The observations continue during the day and the night.

16. Amongst other things, the ACCT guidance states that prisoners should be cared for in a safe environment. It is for the case review team to decide the most appropriate place to locate an individual prisoner within a prison.

Counselling, Assessment, Referral, Advice and Throughcare (CARATS)

17. Organisations specialising in the treatment of substance abuse have drugs workers based in most prisons. CARATS workers run programmes, and can offer counselling, support and referral to rehabilitation centres to prisoners and on release. Access to CARATS is voluntary, by application.

Cell Sharing Risk Assessment (CSRA)

18. In order to make sure that unsuitable prisoners do not share cells, a cell sharing risk assessment is completed by reception staff when a prisoner first arrives at the prison.

Emergency code and medical bags

19. HMP High Down operates a three code emergency system. Code 1 indicates a life threatening emergency (heart attack, hanging). Code 2 indicates an act of self-harm (fitting or non life threatening) and Code 3 represents a minor incident (such as a burn or broken leg). These codes are also known as red (Code 1), amber (Code 2) and green (Code 3).

20. When a Code 1 is used, healthcare staff must attend with their black emergency bag. Amongst other equipment, it contains observation equipment, a blood pressure machine, pulse meter, minor dressings, and some emergency medication such as adrenaline. Each houseblock has its own emergency red bag which contains an oxygen cylinder, airways, oxygen masks, an ambi-bag and a defibrillator. When a Code 1 is announced, and if required by the healthcare staff, houseblock staff will bring the bag to wherever the incident has occurred.

Mental Health In-Reach Team

21. The In-Reach team offers a mental health service for all prisoners who have enduring mental illnesses. They also treat and support prisoners who have mental health problems, offering intervention in crisis situations. The team supports prisoners who are on ACCT documents, and attends most ACCT review meetings.

Reception

22. On arrival at HMP High Down, all paperwork is checked before prisoners are taken off the escort vehicle. Staff check warrants to ensure they have the correct prisoners in custody, and then set up the necessary records. The prisoner is taken from the vehicle and booked in by the senior officer on the front reception desk. Details of the prisoner and their offence are recorded, together with any identified concerns.

23. All prisoners see the first night in prison officer, reception officers, and the nurse on duty. Address and next of kin details are obtained, prisoners are searched, their property is logged and they are health screened, before being placed in a holding cell ready to be taken to a wing.

Roll check

24. The roll check is the physical count of the number of prisoners on each wing within a prison. Roll checks occur on a number of specified occasions during the day and night, and staff sign that the roll is correct.

Sealed key pouch

25. The High Down night order instruction describes the sealed key pouch as follows:

- "Sealed key pouches containing a cell key are distributed to all night staff patrolling units holding prisoners. They are to be used to gain entry into cells at night in an emergency in order to attend to a prisoner whose life is in danger.

- "On discovering a life threatening incident, staff must raise the alarm by contacting the Control Room. The night patrol officer must decide whether aid is required immediately, or whether any delay may result in a very serious harm or death. If the latter is the case, the officer should break open the sealed pouch and use the key to open and enter the cell. If the life threatening situation is a self harm incident involving a ligature, the cut down scissors must be used whenever possible."

KEY FINDINGS

26. In March 2008, the man appeared in court and pleaded guilty to an offence of witness intimidation. The hearing was adjourned when the man was bailed to await the preparation of a pre-sentence report.

27. The man appeared before the Crown Court in April 2008 and was given an eight month custodial sentence to be served (because of his age) in a Young Offender Institution. He was transferred by the escort service to HMP High Down, pending his allocation to a YOI.

28. After arriving at High Down at around 5.00pm, the man went through the normal prison reception procedures. Part A of the Prisoner Escort Form (PER) was completed by the escorting contractor and noted that the man had a risk of "suicide/self harm". The form said, "solicitor states custody has a history of self harm". His cell sharing risk assessment (CSRA) noted that he had previously abused, and was dependent on, alcohol and drugs. He told staff that he could be aggressive and had health problems that prevented him from sharing a cell. He was assessed as high risk and was to be allocated a single cell on the First Night In Prison and Induction Wing. In answer to a standard question, the man told staff that his next of kin was his partner and this was recorded on his records.

29. When the man was interviewed by the first night in prison (FNIP) officer, he said he had harmed himself since his childhood and had cut himself a year before. He had done this out of frustration but said that he had no intentions of harming himself and had no present suicidal thoughts. He also said he had a multiple personality disorder, Attention Deficit Hyperactivity Disorder (ADHD), and haemophilia. His FNIP record stated that he should be referred to the doctor. The prison's regime was also explained to him.

30. The man also had a reception health screening which was conducted by a registered general nurse. He told the nurse that he had served a previous sentence at HMYOI Huntercombe three years earlier. He said that he was receiving both Prozac (an anti-depressant) and Olanzapine (an anti-psychotic medication prescribed for people experiencing hallucinations and having delusional thoughts). He told the nurse that he had an injury to his right hand which he said he had received when punching a wall. He described himself as a social drinker and admitted that he had used cannabis. The man also said that he had previous contact with psychiatric services, having been diagnosed with ADHD, and had stayed in a secure psychiatric hospital. He said that he had tried to harm himself in the past, but was unable to supply any details of the most recent episode. The nurse did not consider that he was suicidal. No concerns were raised about him during his first night in custody.

31. At interview with my investigator, a nurse said that she was the second nurse to interview the man as part of his health screening. She did so on 17 April, although she only had a vague recollection. She referred him to the In-Reach team because he said he was taking Prozac and Olanzapine. She reported that the man had said he had no intention of harming himself. Wanting to

confirm his prescription, the nurse telephoned the man's doctor in the community and established that he had not been a patient since 2003. His referral to the In-Reach team was given routine priority and he was to be discussed in a referral meeting on 23 April.

32. The safer custody officer received an e-mail from the man's solicitor on 17 April. The e-mail contained the following:

> "We act for [the man] who was sentenced at the Crown Court yesterday to 8 months in a Young Offenders Institution. Counsel acting for [the man] informed the gaolers at Court (with [the man's] consent) that he had a history of self-harming and was informed that this would be marked on his custody record in order to ensure that he received proper care and attention. We have, however, just been informed by HMP High Down that you are unaware of [his] history of self-harm. We were asked to email you to notify you of the issue. Please could appropriate steps immediately be taken to safeguard [the man's] welfare, in light of his history of self-harm."

33. The man completed his prison induction during the next couple of days and was introduced to a range of advisors including CARATs, the chaplaincy, the legal services officer, the housing advisor and Jobcentre Plus.

34. On 21 April, the safer custody officer responded to the solicitor's e-mail, stating, "Thank you for this information, I have passed it on to [the man's] houseblock staff who have marked his records and will monitor accordingly." This information was recorded in the houseblock observation book so that the staff would be aware. No concerns were raised about the man.

35. Two days later, the man gave permission for healthcare staff to contact his psychiatrist in the community. The prison doctor completed a pro-forma which was signed by the man. The pro-forma explained that he was under the care of High Down and further information was needed regarding his previous treatment. He was prescribed valerian tea bags (which are a common remedy for insomnia) because he said he was not sleeping properly. The following day, he was prescribed Metronidazole (used mainly to treat infections, including dental infections), Ibuprofen (a pain reliever) and Amoxicillin (normally used to treat bacterial infections).

36. A fax was received in the prison healthcare unit on 25 April from the man's psychiatrist in the community, from the Mental Health NHS Trust. The fax included a psychiatric report written by him in January 2008 in which he described the man as having a severe personality disorder, which mostly stemmed from his traumatic early childhood. He said that he was often irritable and aggressive, was highly impulsive, and had attempted suicide. Attempts to encourage him to accept outpatient counselling had not been possible as he failed to attend. He had also failed to contact the local support networks for patients with personality disorder, despite continuous encouragement. It had been thought that low doses of anti-psychotic medication could temper his emotional instability. However, the report concluded that the man had

discontinued the medication and was discharged from further psychiatric outpatient care, with no recommendation for further ongoing treatment.

37. The next day (26 April), the man was assessed on the houseblock by another nurse who referred him to the MHIT. He noted on the referral that the man "claims to be on Fluoxetine [Prozac] and Olanzapine. Not coping without his meds".

38. As a result of the referral from the nurse that did the healthscreening (on 17 April) to the MHIT, the man was assessed by another nurse. At interview with my investigator, the MHIT nurse said that she had a lot of experience in the mental health field, including working as a community psychiatric nurse. Her work for the MHIT included assessing, screening, supporting and monitoring prisoners identified with severe and enduring mental health problems, referring them to hospital if appropriate, and ensuring that they receive proper treatment.

39. The MHIT nurse met the man around 10.00am on 29 April and their interview lasted for around 30 minutes. In interview, she described him as very calm and cooperative. He engaged in conversation and had talked a little about his childhood, although it saddened him. He also mentioned that around two days earlier he had harmed himself by punching the wall, but had not done so since. He said he was having trouble sleeping and had not found the valerian tea bags helpful. He was very clear that he wanted to be prescribed Olanzapine which helped him remain calm.

40. The MHIT nurse said that the man listened to her intently. She explained that she was not opposed to prescribing Olanzapine, but it was necessary to find out more about his medical history and consider an alternative medicine. She explained to him that taking Olanzapine long term can have side effects including changes to a person's metabolic rate and a sedative effect. She would consider referring him to the MHIT psychiatrist, if she felt there was a need for further assessment and treatment.

41. In the meantime, the MHIT nurse discussed the possibility of the man taking capoeira classes (run by a movement psychotherapist) to help him deal with his anger management. (This is a form of non-contact martial arts and the course took place each week.) However, he said he was exercising in his cell which helped prevent his anger from building up. The MHIT nurse said she intended to discuss the man at the next team meeting, which was held every Wednesday.

42. After meeting the man, the MHIT nurse faxed a letter to his psychiatrist in the community to ask for further details of the treatment he had received so that staff at High Down could treat him appropriately.

43. The man was assessed by the MHIT psychiatrist the next day (30 April) at around 10.40am, as a result of the houseblock nurse's referral on 26 April. The MHIT nurse was, however, unaware of the appointment. At interview with my investigator, the MHIT psychiatrist explained that she only assessed the man on one occasion.

44. The MHIT psychiatrist was already aware of the man's psychiatrist in the communitys' report when she met him. He was slightly anxious, but otherwise engaged well with her. He denied having any plans or thoughts of harming himself, and displayed no signs of major psychiatric illness or of substantial mood disturbance. He discussed his previous medications, including Olanzapine and Fluoxetine, and said he had stopped both because he felt they were not working. He said he was relieved that his partner and grandmother both lived close to the prison as they could visit.

45. Although the MHIT psychiatrist told my investigation that she had not attended formal ACCT training, she was familiar with the procedure involved and had previously opened an ACCT document for another prisoner. She did not detect any immediate risk during her assessment of the man and did consider it necessary to open an ACCT document.

46. After her discussion with the man, the MHIT psychiatrist agreed that he should be referred to the movement psychotherapist. He now seemed happy with a referral to undertake this therapy, and was "quite insightful and able to make a link between his impulsive behaviour and problems in relating to others and his difficult childhood."

47. The MHIT psychiatrist told my investigator that she subsequently contacted the psychiatrist in the community's, at his office. She was unable to talk to him directly but spoke with his secretary. His secretary later gave the MHIT psychiatrist the response from the psychiatrist in the community and advised her on the man's medication.

48. The MHIT psychiatrist intended to discuss the man at the next team meeting, although she did not intend to make definite decisions about treatment until he was assessed by the movement psychotherapist. The plan was for the MHIT nurse to monitor his mental state and refer back. The referral from the MHIT psychiatrist was written the same day (Wednesday 30 April) that she assessed the man. The movement therapist subsequently wrote to him on 9 May offering an initial assessment on 16 May.

49. On 3 May, the man was subject to an adjudication for fighting on the houseblock. The charged was proven and the punishment was the loss of seven days' privileges. Nothing was noted on his records to suggest that he sustained any injuries from the incident.

50. The MHIT nurse did not manage to speak with the psychiatrist from the community until late afternoon on Friday 9 May. He told her that he had already faxed a report of the man's medical history to the prison. The MHIT nurse located the fax and intended to share its contents at the next weekly meeting on 14 May. She found nothing further in the psychiatrist from the community's report to change her plans in respect of the man.

51. No staff had suggested that the man might want to harm himself.

Events on 13 May

52. The man was due to be transferred to HMP Norwich (which has two wings used to hold young offenders) on 14 May, and he was told about this on the morning of the day before. He had been identified as being suitable for transfer as he had no outstanding court appearances and was not otherwise thought to be a concern. On the afternoon and evening of 13 May, he made eight telephone calls shown in chronological order below. (The content of these telephone calls only became known to the Prison Service after his death.)

53. The first three of the eight calls the man made are summarised below:

Telephone Call 1 (made at 3.31pm) to his mother's partner. The man asked for someone to call his solicitor in order that his prison transfer be stopped.

Telephone Call 2 (made at 3.59pm) to the man's partner, again requesting that his solicitor be called to stop the transfer.

Telephone Call 3 (made at 6.16pm) again to the man's partner. She said that she had called the solicitor and they could only send a letter. There was a very short discussion about where Norwich was, and then he said that he would call her back on the house telephone.

54. Around the time the man made his third telephone call, the evening meal was being served. At interview with my investigator, an SO said that he was the officer in charge of houseblock 3. He had spoken with the man around 6.15pm, and he had said that he had received notification of his transfer to Norwich. He said he did not want to go as he was a local boy and his relatives would find it difficult to visit him. The SO told him that High Down was a local prison and it was normal to move prisoners on as soon as possible. The SO said the conversation with the man typified the sort of conversation he regularly had with prisoners. On hearing the officer's response, he displayed no "desperation or worry" in his voice.

55. The next two telephone calls were made by the man after speaking with the SO and are summarised below.

Telephone Call 4 (made at 6.22pm) to the man's partner. The initial conversation concerned the distance to Norwich and the difficulty visiting. The conversation then turned to fabricating a story about his grandmother dying and his son having strokes. He said that he "might attempt to hang myself tonight" but implied this was only to make himself unfit to travel. He told his partner what she should say about his grandmother and to ask for the Governor of the prison. He stressed that his partner should say that "he told me that if he moves he is going to hang himself tonight". His partner was concerned at the man's proposed plan and asked him for reassurance that he would not actually go through with it. He promised that he would not.

Telephone Call 5 (made at 6.31pm) to his mother's partner, who passed the telephone to the man's mother. The conversation started by him telling her

about the proposed transfer to Norwich. He asked his mother to telephone the prison and, in an attempt to stop his transfer, to say his grandmother was ill.

56. At approximately 6.45pm, an officer began his duty in the prison front gate. He received a telephone call from the man's partner who said that she wished to raise concerns about the man's welfare. She told the officer that the man was being transferred to another prison, and would "do something serious" to himself if they made him go.

57. The front gate officer reassured her and said that he would pass her concerns on to the staff on the houseblock. They in turn would speak to the man personally and explain the reasons for his transfer, as well as listen to any concerns he might have. The front gate officer explained to the man's partner that, if staff felt that the man was at risk of harming himself, he would be placed on an ACCT document and monitored. He said the man's partner appeared to be content and their conversation ended.

58. Around 15 minutes later (7.00pm), the front gate officer telephoned houseblock 3 and spoke to the SO. He explained that he had received a telephone call from the man's partner raising concerns about the man, and asked if a member of staff would check on him. The SO said that he had only recently spoken to him and described him as laughing and joking, giving no cause for concern. Nonetheless, the SO said he would speak with him again to check on his well-being.

59. The SO did speak to the man and told him that his partner had contacted the prison to raise concerns about his welfare. Their conversation lasted for about five minutes and he reiterated his reasons for not wanting to leave High Down. They also discussed the distance between Norwich and his family. The SO told my investigator that "in no terms did he express he was likely to self-harm or injure himself". As their conversation ended, the SO told the man that he was willing to speak to the duty governor the next day about his transfer. He responded and said okay and walked away. The SO said he did not record his conversation with the man, as it had caused him no concern.

Telephone Call 6 (made at 7.02pm) to the man's partner (with an unknown woman also present). Again the transfer to Norwich was discussed and the other woman said that [the man's partner] had called the prison and was working hard on his behalf. He then talked to his partner, asking her what she had said to the prison. They talked about how he felt about going to Norwich and how he was going to be treated because of his accent. He said he would just get into trouble if he was in a YOI. He said that he was settled at High Down and had friends. They went on to have a general conversation about the prison regime, including reference to the evening meal he had just eaten which he referred to as "rabbit food".

60. At approximately 7.20pm, the front gate officer received a telephone call from the man's mother, who was also concerned about her son's safety. In interview, the front gate officer said that he offered reassurance that her son

would be spoken to. The front desk officer then made a note in the Observation Book of the telephone call and the actions that he had taken that evening.

Telephone Call 7 (made at 7.29pm) to the man's grandparents. He told them about the transfer to Norwich and had a general conversation. He asked them to ring the prison on his behalf to tell them about his grandmother's illness to try to stop his move to Norwich.

Telephone Call 8 (made at 7.38pm) to the man's partner. He said he would talk to a Senior Officer the next day. He told her not to send him any money until he knew where he would be. His partner asked him to ring her in the morning.

61. At interview with my investigator, an operational support grade (OSG) said that he began his night duty at 7.45pm. Stationed in the prison front gate, his first duty was to book in the night staff as they arrived. At about 8.00pm, he took a telephone call from a woman who said she was the man's grandmother. She gave his prisoner number and said she was calling because the man's "other Nan is gravely ill and we don't think he should be transferred tomorrow, we feel he should be close at hand in case anything happens".

65. The OSG said he explained to the man's grandmother that there was nothing he could do to stop any transfer of a prisoner. He added that he could speak to the orderly officer (the officer in charge of the prison during the night), and that it was usually possible for a prisoner to attend a family funeral. His grandmother said that was okay and then enquired where exactly Norwich was in relation to High Down, and whether financial assistance with travelling expenses could be provided. She also asked the OSG if he knew that the man was a haemophiliac, with a forthcoming hospital dental appointment, which he would miss if he were to be transferred.

66. As staff are not allowed to discuss a prisoner's details over the telephone to someone whose identity is unknown, the OSG suggested that she call the prison healthcare unit in the morning to clarify whether they were fully aware of the man's medical history. He told my investigator that their telephone conversation lasted around four or five minutes before the man's grandmother thanked the OSG and the call ended.

67. The OSG said that the man's grandmother was polite and friendly throughout, and did not mention her grandson wanting to harm himself. He therefore did not make a note of the conversation and treated it as a "standard phone call", one of many which are received.

68. Another SO confirmed in interview that he was the night orderly officer on duty on the evening of 13 May. His role was to ensure the smooth running and security of the establishment, and to deal with any incidents that arose throughout the night. He had a team of officers who moved around the prison. He also visited each houseblock himself approximately four times during the night. He described the evening of 13 May as busy. Unfortunately, the prison

had experienced a death in custody (from natural causes) earlier that day and so a number of staff were still on duty.

69. Another OSG commenced his night shift duty on houseblock 3 at 8.15pm. Handover from the day staff took place around 8.30pm, after which he checked all the prisoners who were on an open ACCT.

70. Around 11.30pm, the night shift OSG responded to a cell bell alarm on the B spur third landing of houseblock 3. When he arrived at the appropriate cell, he discovered that the occupant had harmed himself by cutting his ear. The night shift OSG immediately used his radio and called for assistance from the night orderly officer, the assistant night orderly officer, and the on duty nurse. The night duty nurse was carrying the radio with call sign Hotel 2, which meant he was the first person to respond to any emergency.

71. The night orderly officer responded to the Code 2 emergency call made by the night shift OSG, with an officer and the nurse on duty. When they arrived on houseblock 3, and went into the prisoner's cell, they found that he had sliced off part of his ear. The night orderly officer and the assistant night orderly officer escorted him to the healthcare inpatients unit for treatment. The night orderly officer left other members of his team in the healthcare unit whilst he made his way to the main gate to continue his duties.

72. The night shift OSG continued his night duties after the prisoner was removed from the wing. At 11.58pm, the cell bell for cell 34 house block 3, C spur, went off. This was a three man cell. When he looked through the cell observation panel, he could not see the prisoners' faces but heard voices. One of the voices said, 'Oh, I think it would be nice to check the guy next door.' The night shift OSG looked through the observation panel of the cell next door, cell number 35. The light was on and he could see the man hanging by the window, with his head facing down.

73. The night shift OSG raised the alarm by using his radio to call a "Code 2". He told my investigator he thought that this was the code listed for incidents such as self-harm. The night orderly officer heard the emergency call over his radio whilst he was en route to the main gate and realised that his assistant would be able to respond quicker than he could. He radioed a request for Hotel 5 (another nurse on duty) to attend as he was aware that the other nurse on duty was already treating the prisoner who had recently self harmed. The night orderly officer then telephoned the wing office on houseblock 3 to find out what had occurred.

74. The night shift OSG heard the office telephone ring and quickly ran to answer it. He told the night orderly officer that the man was hanging in his cell. The night orderly officer used his radio to change the emergency call to a Code 1, which required all staff to attend the cell. The night shift OSG then rushed back to the cell, broke the seal on his key pouch, unlocked the cell door and went inside to assist the man. He told my investigator that he was aware of the security implications this posed, but he was the sole occupant of the cell and he had entered the cell in the hope of saving his life.

75. The officer that assisted with the previous incident told my investigator that the initial emergency call made by the night shift OSG was a Code 2. He was aware that the emergency codes had changed recently, and "hanging" was now placed under a Code 1 call, whereas previously it was described as "self-harm" and listed as Code 2. He said that the night shift OSG, who was fairly new on the night shift, might not have known this. Despite this, the officer said that the emergency call was changed over the radio network within "10 to 15" seconds to a Code 1.

76. When the nurse on duty heard the emergency call Code 2 over the radio (around midnight), he was attending to the prisoner who had earlier harmed himself. He told my investigator that he asked the officer who assisted with the previous incident to ask her colleague (another nurse on duty) to go to the second emergency. This was done, but within seconds the control room upgraded the emergency call to a Code 1 which meant that all staff should attend. The nurse on duty immediately left the prisoner with the officer, collected the black emergency bag and ran to houseblock 3. The officer who assisted with the previous incident arranged for the other prisoner to be locked up and also made his way to the man's cell.

77. Having gone inside the cell, the night shift OSG held the man's waist and raised him up to try to take the pressure off the ligature (which was made from ripped bed sheets). In doing so, he could feel that he was "very, very cold and turned to blue".

78. The assistant night orderly officer responded to the Code 1 emergency call and made her way as quickly as possible to houseblock 3, along with another officer. She collected the red emergency bag (there is one located on each wing) on her way to the man's cell. Both officers met the second nurse on duty en route. They arrived at his cell within a minute, with the nurse on duty only seconds behind them.

79. When they reached the cell, the assistant night orderly officer found the night shift OSG holding the man who was facing as if he was looking out the window. There was an officer already on scene, he had also gone inside the cell and helped the night shift OSG. The ligature that was around the man's neck became loose and the officer on scene pulled it over the man's head as they lowered him to the floor. Both nurses got their medical equipment ready and began to assess the man. The assistant night orderly officer then started to remove some of the furniture in the cell to make space for them to work.

80. The second nurse on duty told my investigator that he checked the man for signs of life, but there was no response. He was grey and cold, although the window being open might have been a contributory factor. The ligature mark around his neck was very deep. He started cardio pulmonary resuscitation (CPR). He carried out heart compressions whilst the officer on scene administered breaths into the man's mouth. The nurse on duty assisted with CPR, and he was checked regularly for signs of life. The defibrillator was used to check if there was any activity in his heart.

81. The night orderly officer arrived at the man's cell within five minutes. He had already asked for an ambulance and, when he arrived at the cell, he sent two officers to the gate to escort the ambulance crew. When he looked in the cell, he saw the man lying on the floor and CPR being administered. Aware that he was being attended to and, being a member of the prison's care team, he offered support to the night shift OSG who was in shock.

82. The nurses and staff continued to try and resuscitate the man until the ambulance crew arrived at about 12.18am. They too checked him for signs of life and used their heart start machine to check the activity of his heart. Sadly, there was no response and they pronounced his death at 12.20am.

83. Letters written by the man were found in his cell and placed in an evidence bag. One of the letters was addressed to the Governor. It was dated 13 May. The man had written that the only thing keeping him strong was his family but, "I'd rather die than be took further away from them." He declared that he was going to take some Metronidazole and Ibuprofen tablets and would then hang himself.

After the man's death

84. The night orderly officer opened the death in custody contingency plans, and began by sealing the man's cell to await the arrival of the police. He then began contacting the relevant agencies to inform them of the death, and requested details of the man's next of kin.

85. The duty governor had recently left the prison for home when he was contacted and informed of the man's death. He returned immediately, arriving at approximately 12.30am. Once he was briefed on the situation he made his way to the man's cell where he spoke with the night shift OSG and the night orderly officer. The duty governor confirmed with the night orderly officer that all the necessary agencies had been contacted. Arrangements were made to interview all prisoners on open ACCT documents.

86. The police and the coroner's officer remained at the prison for some time interviewing staff.

87. Having been informed of a death in custody at 12.40am, the chair of the IMB made her way to the prison. She told my investigator that she became aware of suggestions that the three prisoners in the next door cell knew that the man did not want to be transferred and that his death was to stop the move. She said that his stay of three weeks on the Induction Wing was not customary, and prisoners would normally be there for just one week. She said this was likely to have happened because of the lack of suitable young offender spaces across the prison estate. High Down had a large number of young offenders at the time.

Hot debrief meeting

88. The duty governor held a hot debrief meeting at 5.30am for all staff who were directly involved when the man was discovered. Staff discussed their

involvement during the incident and statements were collected. The night shift OSG was excused from the meeting and sent home as he was still in shock.

The prisoners in the adjoining cell

89. At around 2.00pm the following day (15 May), the chair of the IMB spoke with one of the prisoners in the cell next door to the man. The prisoner said that the man had been enquiring about Norwich on the morning of 13 May and had said he did not want to leave High Down. Later that evening during their association, he had said he was "going to leave a letter for my girl". The chair of the IMB said that the prisoner told her that, after lock up time, it was normal for the man to join in on conversations with him and his cell mates next door. On this occasion, they had last spoken to him between 9.00pm - 9.30pm. It was also usual for any of the three prisoners in the cell to bang the wall to get a response from the man, which is what was apparently done at around 11.50pm. However, he had not responded. The prisoner told the chair of the IMB that he had pressed his cell alarm bell because it had gone quiet in the man's cell.

90. When my investigator made his first visit to High Down, he attempted to speak with all three prisoners in the cell next to the man. However, all three men refused to speak to him. My investigator also wrote to all three prisoners, but got no response. At a later date during the investigation, a further request was made. On this occasion, one of the prisoners agreed to speak with my investigator. He was the only one of the three still at High Down at the time.

91. The prisoner told my investigator that he got along with the man, and had known him before coming to High Down. The man had told him on several occasions that he needed his "meds" and was getting "stressed". He had once stated that he had had mental health problems, describing himself as having three personalities.

92. The prisoner said the man was unhappy about his prospective transfer to Norwich because the prison was far from his family and it was a young offender institution. He had believed he would just get into fights in Norwich because of the immaturity of younger prisoners. The prisoner said that he had himself served a period in custody in Norwich, and tried to reassure the man that it was not too bad. The prisoner said that the man gave no indication that he was so unhappy about the transfer that he would harm himself. On the night that he took his life, the prisoner said that he was asleep when his cell mate had pressed the cell alarm.

Next of kin

93. The man's partner was listed as his next of kin. Two governors went to visit her at around 7.00am on 14 May to break the news. They told her of the circumstances surrounding the man's death and that the prison's family liaison officer (FLO) would be her direct contact with the prison.

94. The prison FLO telephoned the man's partner soon after the governor had spoken to her and arranged to visit her at home that morning. However, the man's partner went to the prison instead. The prison FLO explained his role and the assistance the prison could offer. During the course of the week, the prison FLO arranged for his partner to view the man's body, and he

accompanied her at her request. The man's family (mother, stepfather, father, grandparents and uncle) were also there. His partner and the man's family were offered the opportunity to visit his cell.

95. The man's mother told my FLO that his grandmother had telephoned the prison on the morning after his death between 7.00am and 9.45am to try and halt his transfer. She was not informed of his death until later that morning (11.00am), when she received a telephone call from the prison. The man's grandmother had then told his mother.

96. Shortly afterwards, the man's mother contacted the prison FLO and advised him that she also wished to be recognised as the man's next of kin. The prison FLO therefore ensured that he kept in regular contact with both the man's partner and his family, whilst he assisted them to arrange the funeral. The funeral was delayed for a number of months. The prison offered to assist with the costs.

Post Mortem

97. The post mortem confirmed that the cause of the man's death was hanging. Diphenhydramine, Ibuprofen and Metronidazole were all detected in his blood, although at concentrations lower than expected following therapeutic doses and each might be the residue of therapeutic doses taken many hours before death. No alcohol and other drugs were detected. All the medications were prescribed to him.

98. Diphenhydramine is an anti-histamine drug used for its sedative and hypnotic properties in a number of 'over the counter' preparations such as 'Nytol'. Ibuprofen is a non-steroidal anti-inflammatory drug that has pain killing and anti-inflammatory effects. Metronidazole is an antibiotic.

ISSUES

99. The clinical review makes seven recommendations. I refer in my report to the three which I believe are the most pertinent to my investigation, and have made the Primary Care Trust aware of the remainder.

Reception health screening

100. On the man's first day in prison custody, he received a health screening during which it was identified that he had been treated previously by community psychiatric services and prescribed psychiatric medication. Despite the fact that the screening tool states that, in such circumstances, a mental health assessment is required, the man was not referred for an assessment. He was, however, referred the following day when he was examined by a nurse. This resulted in him receiving a mental health assessment appointment on 29 April with the Mental Healthcare In-Reach nurse. Although the one day delay in referring him did not contribute to his death, the instructions on all healthcare screening tools should be followed rigorously.

    The Head of Healthcare should remind staff to adhere to all instructions on screening tools.

101. A second referral for a mental health assessment was made on 26 April by a houseblock nurse as the man said he needed his medication. As well as seeing the MHIT nurse, he was assessed by the ln-Reach psychiatrist who also referred him to the movement psychotherapist on 30 April. He received notification of an appointment to see the movement psychotherapist in May. There was no suggestion on any of the referral forms that this was an urgent referral, and indeed the first referral form said that there were "no intentions of self harm reported at reception". The clinical reviewer comments that the man's referral times were broadly similar to those that would be experienced in the community, and the appointment with the movement psychotherapist was extremely prompt in comparison to psychotherapy services in the community.

Request from external agencies for medical information

102. A faxed copy of the psychiatric report was received in the prison on 25 April 2008, which was before the MHIT nurse assessed the man. She was unaware that the report had already been requested by healthcare staff and had in fact been received. As a result, a further request was made because the report had not been brought to her attention. The clinical reviewer says that it appears that the psychiatrist from the community's report was filed within the man's medical records.

    The Head of Healthcare should ensure that a central system is put in place for the requesting and receiving of medical information from outside agencies.

ACCT training

103. Following their assessment of the man, neither the MHIT nurse nor the MHIT psychiatrist considered it necessary to open an ACCT. Neither were ACCT trained, although both said they had developed a working knowledge of how to use the document. I believe all members of mental health staff should be ACCT trained.

The Head of Healthcare should ensure that all Mental Health In-Reach staff receive ACCT training.

The planned transfer to HMP Norwich

104. The man was given 24 hours notice of his transfer to Norwich. This timeframe is normal practice within the Prison Service.

105. The clinical reviewer notes that there appeared to be a disconnection between the services which manage prisoner location and those that provide medical input. Neither was aware of what action the other had arranged for the man. He had been referred to the In-Reach team and a referral had been made by that team to the movement psychotherapist. He seemed to accept this referral as a possible avenue to address his anger and mood. However, he would not have been able to follow this through as he would have been transferred to Norwich before his appointment.

106. It is important that there is some mechanism whereby those responsible for determining a prisoner's transfer are aware of any medical appointments, both internal and external. Indeed, at interview with my investigators, the MHIT nurse said that she would have arranged to visit the man had she known of his impending transfer. Attempts could have also have been made to liaise with the Mental Health In-Reach Team in Norwich to ensure a continuity of care. The Prison have responded to this issue and said that a system is already in place for identifying medical need that would stop a prisoner being transferred if necessary. However I make the following recommendation as in this case the In-Reach nurse was unaware of the man's impending transfer.

The Governor should review the procedures for transfers to ensure that medical considerations are given full weight, and that all relevant information is made available to the receiving establishment.

The family's concerns

107. The man was distressed after being told of his transfer, as shown by the number of telephone calls he made to his partner and family. He suggested in these calls that he might harm himself.

108. Although staff were unaware of how many calls the man had made, they did receive the follow-up calls from his partner and mother asking that the transfer be stopped and indicating concern for his welfare. I believe that appropriate action was taken in that he was spoken to and confirmed that he did not wish to

transfer to Norwich. The staff who spoke to him assessed that his behaviour and responses to their questioning did not give them cause to believe that he would harm himself. No further action, such as the opening of an ACCT document, was thought necessary and none was taken. With hindsight, it is easy to question their judgements, but I am satisfied that the information from his family was taken seriously and proper care was taken to check on his well-being.

Prison Mental Health In-Reach Team

109. The clinical reviewer has said that the medical history presented by the man is by no means unusual amongst young offenders, and considers that the In-Reach team would benefit not just from psychiatric services, but also from the input of a psychologist. I have made a recommendation on this issue in a previous report and understand that psychology sessions were to be made available from November 2008. Sadly, this was after the man's death.

Other issues

110. The man's mother believed that her son had damaged his cell and called out his partner's name on the evening before he died. My investigator found no supporting evidence that he had done either thing. Neither the prisoner who spoke to the chair of the IMB Chair, nor the prisoner who spoke to my investigator, said they heard any disturbance from his cell prior to the emergency call being raised. The police also did not note any damage to his cell in their report.

111. The man's mother was not named as next of kin on his prison records. As a result, High Down did not immediately notify her of her son's death. Understandably, this caused her some distress when she was told by her own mother some hours after his passing.

112. I continually emphasise the importance of notifying next of kin as quickly as possible after a prisoner's death, and this was duly done by High Down. However, common decency also suggests that contact should be made with other members of the family so far as this is possible. All the more so in the case of the mother of a young man. Although I make no formal recommendation, the Governor may wish to consider how best to notify other family members following a death in custody – especially in the case of young prisoners, and especially when those family members have been in touch to express concerns about the prisoner's well-being.

CONCLUSION

113. The man had previously harmed himself and had been under the care of community mental health services. When he arrived at High Down, he declared his medical history and this information was duly checked. However, he presented as someone who was coping with his vulnerabilities and his imprisonment, and there appeared to be no need to place him on ACCT monitoring. His well-being was confirmed by two separate mental health assessments.

114. Indeed, the man raised no concerns until he was informed of his transfer to Norwich, some considerable distance away from his family.

115. Reviewing the phone calls that the man made to his family, it is unclear whether he intended to take his own life or wanted to hurt himself so that he would be unfit to transfer. The letter addressed to the Governor suggests a firmer intention to kill himself.

116. I wish to record my admiration for those staff who responded quickly and compassionately in an effort to save the man's life. I do not underestimate the physical and emotional demands placed upon them.

RECOMMENDATIONS

1. The Head of Healthcare should remind staff to adhere to all instructions on screening tools.

2. The Head of Healthcare should ensure that a central system is put in place for the requesting and receiving of medical information from outside agencies.

3. The Head of Healthcare should ensure that all Mental Health In-Reach staff receive ACCT training.

4. The Governor should review the procedures for transfers to ensure that medical considerations are given full weight, and that all relevant information is made available to the receiving establishment.