Investigation into the circumstances surrounding the death of a man at HMP Manchester on 7 February 2009

Report by the Prisons and Probation Ombudsman for England and Wales

March 2010

This is the report of an investigation into the death of a man. He was found hanging in his cell at HMP Manchester on 7 February 2009 and was pronounced dead by doctors at hospital shortly afterwards. He had been in custody for about six months.

I would like to offer my personal condolences to the man's family, friends and everyone affected by his death.

The investigation was undertaken by one of the Ombudsman's investigators. In addition, Dr A was asked by the local NHS to undertake a review of the man's clinical care, and I am grateful for his contribution to the investigation. I must also thank the Governor of Manchester and his staff for their participation in the investigation.

Having been arrested for drug offences, the man was remanded into the custody of HMP Manchester to await further court hearings. He quickly settled in prison, addressing his substance misuse problems and gave staff no concerns. He appeared in court on 5 February and was told he might face further charges for a different offence. His cell mate said that this had affected his mood. Within a week of the court appearance, the prison authorised a request from the police for the man to be arrested for further questioning. I have however found no evidence as to whether he was told.

Staff and prisoners spoke to the man shortly before the evening meal the next day and he was fully expected to carry out his job working in the kitchen servery. When he did not arrive, he was checked by a fellow prisoner who discovered him hanging in his cell. He had given no indication to staff or other prisoners that he intended to harm himself.

My report includes four recommendations.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Jane Webb
Deputy Ombudsman **March 2010**

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SUMMARY

The man who is the subject of this report was charged with drug offences and remanded into custody at HMP Manchester on 19 August 2008.

He had a history of drug misuse which he disclosed during his reception at the prison. He said that he had used heroin and cocaine in the last month. He was also taking Subutex which is used to help people overcome their addiction to stronger drugs such as heroin and had last took some on 17 August. As a result he was put on a detoxification programme. The doctor noted that he had no thoughts of self-harm.

He duly completed his detoxification and asked to be placed on the voluntary drug testing unit as he wished to remain drug free. Staff said he settled well into prison regime, taking on the role of a wing cleaner and working in the kitchen servery. He had regular contact with the Counselling Assessment Referral Advice and Throughcare (CARATs) officer who assisted the man manage his drug misuse. A care plan was drawn up by the CARATs officer that included a transfer to a therapeutic prison after he was had been sentenced.

On 30 January 2009, he attended a court hearing and was told he might face further charges for a different offence. When he returned to the prison, he told staff but did not show any concern. His cell mate said however that it affected his mood and he did not talk as much as usual.

The same day, the police made a formal request to the prison to arrest the man. He was told that he was to be collected on Monday 9 February, taken to a police station for further questioning, and returned the same day to prison. The request was authorised on 5 February but there is no evidence that he was told about it informed and staff had no concerns about him.

On the evening of Friday 6 February, staff and prisoners spoke with him shortly before the evening meal was served. He was last seen going into his cell to use the toilet sometime between 4.10pm and 4.35pm. When he did not return, his cell mate became concerned. He went into the cell, where he discovered him hanging in the toilet area.

The alarm was raised immediately. Staff went into the cell and called for medical assistance. Cardio pulmonary resuscitation (CPR) was carried out until the paramedics arrived and took over. He was subsequently taken to hospital where attempts to resuscitate him failed. He was pronounced dead at 5.51pm by the hospital doctor.

My report includes four recommendations which relate to the availability of CCTV and telephone transcript data, the process of administering police production orders and first aid training and equipment.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened by one of the Ombudsman's investigators on 12 February 2009 when he met the Governor and some of his staff. Notices of the investigation and terms of reference had already been sent and invited anyone with any information to contact the investigator. As a result, the investigator interviewed one prisoner.

2. The investigator also met the Head of Healthcare, representatives of the Prison Officers' Association, a representative of the Independent Monitoring Board and the Head of Decency and Safety. He visited all parts of the prison including the wing where the man lived, and met the prison's liaison officers, Senior Officer B and Principal Officer C.

3. The man's prison records, including his medical record, were made available to the investigator during his initial visit to the prison. A full set of documents were provided, already clearly filed, which he found extremely helpful. Additional documents were made available when he returned to conduct interviews. Although CCTV and telephone transcript data was passed onto the police immediately after the man's death, no copies were made for the investigator.

4. A clinical review was commissioned from the local NHS of the man's medical care. Although there was a delay in its completion, I am grateful to their consultant, Dr A for his review. As part of his review, Dr A interviewed the Head of Healthcare at Manchester, and also reviewed transcripts of interviews undertaken by the investigator.

5. One of the Ombudsman's Family Liaison Officers contacted with the man's parents to inform them of the investigation and give the opportunity to raise any questions or concerns about the care he received. At the time of writing this report, his family have not raised any specific issues. I hope this reports provides them with a better understanding of the events leading to his death.

6. BACKGROUND

HMP Manchester

7. HMP Manchester is a large prison which holds up to 1,269 prisoners. It is Victorian in external appearance but has been refurbished internally. Cells have televisions, electric sockets and sanitary facilities. Manchester holds both unconvicted and sentenced prisoners as well as some high security (category A) prisoners. For this reason, it is part of the high security estate and security within the prison reflects this. The man who died was a category B prisoner.

8. The prison is divided into two main areas. The upper prison contains four wings (G-K) which include the First Night Centre and the induction wing. The lower prison has five wings (A-E). The man spent most of his time at Manchester on B wing. It is split into two halves, commonly known as the inner and outer. He was located on the outer part of the wing which is at the furthest point from the centre. The wing operates as a Voluntary Drug Testing Unit (VTU) for prisoners who wish to live in a supportive environment away from drug use. Prisoners sign a compact agreeing to be tested for drugs at random. There are opportunities for good peer support, anger management information, access to the Alcoholics Anonymous, drug treatment courses and a more relaxed regime.

9. I wing is the detox unit and works with prisoners who are withdrawing from drugs or alcohol, particularly amongst new prisoners. When a prisoner comes into reception, a sample of their urine is taken. If the sample is positive, the prisoner is referred to I Wing for a detoxification programme. Prisoners who are dependant on alcohol live on I wing as well. The unit also provides advice on harm minimisation and harm prevention, and treat blood borne viruses. A substance misuse nurse sees the prisoner, usually in the morning after their arrival, to carry out an in-depth assessment. The substance misuse doctor then decides what treatment should be provided. Prisoners who need to be prescribed medication are also referred to the substance misuse doctor.

10. The length of the drug treatment programme depends on the individual and can vary between a few days and weeks. Once the individual's programme has been completed, the prisoner moves to H wing which is the second stage of the Drug Treatment Unit where they are located for at least two weeks in order to complete group work courses on drug awareness. Referrals to other agencies are made, including the Counselling Assessment Referral Advice and Throughcare (CARATs) team (who provide a counselling service for prisoners with a history of abusing drugs or alcohol and community drug services.

11. The man’s death was the second apparently self inflicted death to occur at Manchester in 2009 and the 17th such death since the Ombudsman took over responsibility for investigating all deaths in prisons in 2004. None of his recommendations in previous reports are relevant to the circumstances of this death.

12. HM Chief Inspector of Prisons (HMCIP) carried out an unannounced inspection in May 2007 as a follow-up to her 2004 inspection. Her report in 2007 said, about safety at Manchester, that

> "the application of category A procedures to the small number of category A prisoners had implications for the quality of life for all prisoners, 630 of whom were merely category C prisoners. Better and more equitable risk management was required."

HM Chief Inspector of Prisons report spoke about the improvement in staff – prisoner relationships, and in particular the impact of the group officer scheme which meant that a prisoner is allocated a personal officer who is responsible for having regular conversations with them. However, her report also commented on suicide and self-harm procedures that required further attention, especially that insufficient time was allocated to staff involved in safer custody. (I understand that the profile of safer custody issues has risen markedly since 2007 and that measures have been taken to address many of the points raised in her report.)

13. The prison's Independent Monitoring Board (IMB), is comprised of unpaid members of the local community appointed by the Secretary of State for Justice. The Board is required to satisfy itself that prisoners are treated properly. In its most recent annual report covering the period March 2007-February 2008, the IMB said the following:

> "Manchester is a well-run prison which is meeting most of its Key Performance Targets … The Board has witnessed many occasions when staff have demonstrated sensitivity to prisoners' needs. e.g. in Reception on arrival at prison, officers giving information on what was happening and answering any questions ..."

14. In relation to safer custody issues, the IMB commented that "staff do everything they can to prevent prisoners harming themselves". The First Night Assessment and Induction form was described as "working well".

Critical Debrief

15. A critical debrief takes place after a serious incident. It gives the staff the opportunity to understand the incident in greater detail, review their feelings and normalise the reactions that some people experience after a traumatic incident. Benefits include being able to discuss their experiences in a safe and confidential environment.

Cut down tools

16. Fish knives are designed for safely cutting ligatures and are carried by all officers and healthcare staff in contact with prisoners.

Emergency response codes

17. Emergency codes are used to summon staff to deal with a particular situation. If there is a medical emergency Hotel 1 (healthcare) is called over the radio using one of two priorities:

    Priority One
    Life threatening situations, ie hanging, severe blood loss, cardiac arrest

    Priority Two
    Any emergency situation that requires immediate attention from healthcare staff and the prisoner cannot be escorted to the healthcare centre for treatment.

18. Healthcare staff have five emergency bags located around the prison. They contain life support equipment which includes airways, ambu bags (breathing aid), oxygen, needles and syringes. There are defibrillators located with the emergency bags. There are also a number of emergency drugs, which can only be administered in a doctor's presence.

Listeners and Insiders

19. Listeners are prisoners trained by the Samaritans to provide a confidential service for other prisoners. They do not offer counselling but offer support, particularly for prisoners at risk of self harm.

20. Insiders are prisoners who volunteer to work in the First Night and Induction wing and Reception, welcoming new prisoners and explaining the processes they will encounter in the early days of custody.

Reception and induction

21. A Cell Sharing Risk Assessment (CSRA) is opened by reception officer who complete the basic details. The form is handed to the First Night Centre staff where a confidential interview is conducted. The document is then passed to healthcare staff. The CSRA is intended to provide consistent and continuing risk assessment regarding sharing cells. While this is primarily cell sharing it also includes other occasions when space may be shared, for example to accommodate a Listener.

22. Reception staff do not routinely have access to a prisoner's past records and so the prisoner is the main source of information. If a prisoner has transferred in his past record would arrive with him. All prisoners will also have a PER form (document used when escorting a prisoner between prisons, court and police stations) which will include risk pertinent information such as risk to others and self.

23. The initial healthcare screen concentrates on the prisoner's immediate well-being, their mental health, risk of self harm or suicide and any drug or alcohol withdrawal or detoxification issues.

24. All new prisoners are located on the induction wing. If a prisoner is considered vulnerable or is a category A prisoner, they will be located on other more appropriate wings and receive their induction there. Prisoners are asked about any immediate concerns, such as disability, their offence and general well being. The induction includes a further assessment, medical screening, and input from the education and offender management units. Prisoners are given a new reception pack, and telephone pin numbers and visiting arrangements are explained.

Suicide and self harm monitoring

25. The Assessment, Care in Custody and Teamwork (ACCT) procedures aim to help and monitor prisoners at risk of harming themselves. The key aims of ACCT are to create a safe and caring environment, identify prisoners' individual needs, and provide individualised care and support before, during and after a period of crisis.

KEY FINDINGS

Prior to the man's arrival at HMP Manchester

26. The man who died was arrested by the police on 18 August 2008 and charged with possession of drugs with intent to supply. He was held in police custody and appeared before a Magistrates' Court on 19 August, when he was remanded into prison custody and taken to HMP Manchester. The escort document, which records events whilst a prisoner is escorted to and from police stations, courts and prisons, recorded that "drugs/alcohol" were risk factors, stating that he was a heroin and cocaine user. No other risk factors were recorded.

His arrival at Manchester

27. The man arrived at Manchester at 3.13pm on 19 August and went through the usual reception procedures. Officer D went through the prison's first night in custody and assessment booklet with the man to assess any concerns or immediate needs. The Cell Sharing Risk Assessment (CSRA) was completed and identified him as a "medium risk" because he told staff that he had previously had episodes of getting frustrated quickly. He was offered a drink and made a telephone call to his mother.

28. He also had a reception health screening which was conducted by a registered general nurse (RGN), E. Nurse E recorded details of the man's health history on the electronic medical record (EMIS). The man said that he had used heroin, benzodiazepines (commonly used for treating anxiety, insomnia, agitation and alcohol withdrawal) and cocaine in the last month. He was also taking Subutex, last taken on 17 August. A urine test conducted by Nurse E confirmed what he said. He also said that he had taken Tramadol for pain relief.

29. It was recorded on EMIS that the man had no "deliberate thoughts of self harm". He was referred to the prison doctor immediately and the drugs service because of his substance use.

30. He was assessed by Dr F and told the doctor that he felt shaky but had no other concerns. He said he had taken benzodiazepines the previous night and had no current thoughts of wanting to harm himself. The doctor recorded that the man made good eye contact, was coherent, relaxed and did not appear to be in any pain or discomfort. He was referred to the detoxification team the following day.

31. The man was duly located onto I wing. He signed the wing compact to enter the Drug Testing Unit (DTU) and agreed to comply with regular drug tests. He was given further information about the prison and staff noted no concerns.

32. His induction continued the next day (20 August). He saw a member of the chaplaincy team and also received a second health screening conducted by Nurse G. Details again were recorded including his weight, previous

medications and smoking habits. It was recorded that he had back problems from a crumbling lumbar disc.

33. The man then went to the detoxification clinic where he was seen by Dr H. The doctor noted that the man had recently taken Subutex (16mgs), heroin and cocaine. He was also taking Tramadol for back pain. No concerns were recorded about his mental health. The doctor prescribed a Subutex detoxification programme was started immediately and prescribed him medication used to treat drug dependence.

34. On 24 August, having been in custody for nearly a week, staff noted on his wing history sheet that they had no concerns about him. Two days later, he spoke to Dr H and asked for a shorter detoxification. No further details or concerns were recorded about this on his medical record.

35. The man was interviewed on 26 August by Officer I from the CARATs team. This was a routine appointment as part of his induction programme. At interview with the investigator, Officer I said that from their first meeting, the man accepted that he needed help to address his substance misuse problem as he wanted to move on with his life.

36. Officer I carried out a substance misuse initial assessment and completed a Drug Intervention Record (DIR). The man disclosed that he last used cocaine and heroin on 16 and 17 August. His mood was “quite low” although Officer I said he expected this from someone who had recently come into custody. The man said he had no current thoughts of harming himself, had no history of overdoses and had no special needs. He also said that he had previously been in contact with a community drug service.

37. Officer I went on to carry out a fuller assessment of the man which included detailed information about his history of substance misuse, health and personal and social functioning, leisure interests and his offending behaviour. A care plan was drawn up and a copy given to him.

38. On 26 August, he went to court for a hearing. He was examined by a reception healthcare nurse on his return to the prison who reported no concerns.

39. The man saw Dr H on 1 September and complained of back pain. He was prescribed diclofenac diethylammonium gel (pain relief cream). He completed his detoxification programme on 4 September and was moved onto H wing two days later. No problems or concerns were noted.

40. On 8 September, the man asked Officer I if he could be considered for voluntary urine testing. As a result, Officer I referred him to B wing, the voluntary testing unit (VTU). The move would be considered once the man had completed the detoxification programme (which included spending two weeks on H wing for stage two of his treatment programme). Then, once a space became available, he would move to B wing.

41. Two days later, the man was seen by the prison doctor again and still complained of back pain. He asked for the Tramadol to be reinstated to combat his pain. He was examined, x-rayed and referred to see the prison physiotherapist. The doctor prescribed Tramadol 100mg to be taken twice daily.

42. The man was examined by the physiotherapist on 12 September who decided that he should undertake a course of exercises to strengthen his core back muscles.

43. In the meantime, he continued to address his drug use and produced a negative drug test on 11 September. He had a physiotherapist appointment on 17 September, but did not attend.

44. Dr J reviewed the man's back condition on 25 September. His x-ray showed a "mild displacement" and records showed that he had only attended one physiotherapy class to date. The doctor's opinion was that his condition did not justify the level of Tramadol dose he was currently taking. The doctor also considered it necessary to contact his community doctor (Dr L). Dr L's response was that the man had been prescribed Tramadol (100mg) since July 2006. His last prescription was issued on 14 July 2008 and Dr L confirmed that he had planned to reduce the dosage.

45. Dr J therefore reduced the man's prescription to 50mg. He was unhappy and became verbally aggressive. The doctor was concerned at his reaction and his repeated request for Tramadol thinking that he could be dependent on the drug. He referred him to the Mental Health In-Reach Team (MHIT) for a mental health assessment. The doctor reminded him to attend his next physiotherapist class on 29 September.

46. The MHIT nurse collected the doctor's referral the same day. Her advice was that he had already been examined by the detoxification doctor and psychiatrist, Dr H, on 20 August and 1 September and no mental health problems had been identified. The MHIT were therefore unable to give any further advice about his insistence of a higher dosage.

47. The man did go to the physiotherapy class four days later (on 29 September). He was examined again and his back was tested for movement and pain. He told the physiotherapist the history of his back pain and again reiterated that Tramadol was the only medication that helped. It was agreed that the course of physiotherapy back exercises should continue as this would help to ease the man's condition.

48. Officer I next spoke with the man on 1 October. The man, still on H wing, had not yet been interviewed by staff from B wing about moving to the unit. Officer I referred him again and also made a referral to the catering officer, so that he could be involved in constructive activity to help him make use of his time in prison. He also attended his physiotherapist class on 3 October.

49. On 8 October, Officer I had another meeting with the man. They discussed the effects of cocaine risk triggers, relapse prevention techniques and ways of dealing with cravings. He was given information about HMP Lancaster Castle's (a therapeutic prison) 12 step rehabilitation programme. It was considered as the first part of an intensive structured treatment programme and Officer I said that the man could work towards being transferred for their course. He described him as "very receptive" to the idea.

50. A space became available on B wing on 10 October and he was relocated there. As a result he was unable to attend his physiotherapy classes scheduled for 10 and 13 October. He did attend on 15 October, saying that he had been trying the exercises and had now stopped taking his medication. His back exercise routine was continued.

51. The man went to court on 17 November and was convicted for drug offences. He was remanded back into prison custody to return to court on 30 January 2009 for sentencing.

52. Officer K was the man's personal officer. He noted on 13 and 18 December that there were no concerns about him. At interview with the investigator, he described him as a "very pleasant, amenable lad" who gave staff no problems. He also mentioned that he had a good friendship with his cell mate.

53. On the morning of 20 December, the man was seen by the nurse and doctor as wing staff reported that he had a black eye. He told the doctor that he had accidentally banged heads with his cell mate the previous night. At first he had not felt any pain, but in the morning noticed that his eye had swollen and was blood shot. He was examined by the doctor to check for any other head injuries and was prescribed eye drops.

54. A further entry by a new personal officer, Officer M, on 9 January 2009, also reported that there were no concerns with the man. Officer M told the investigator that the man had taken on the job of a wing cleaner and also worked in the servery, serving meals to other prisoners. He was doing very well and got on with the other cleaners on the wing that he worked with. In her role as Cleaning Manager, Officer M usually spoke to the man daily.

55. On 15 January, Officer I reviewed his care plan with him. There were no problems and they again discussed a move to Lancaster Castle. They agreed to wait until he was sentenced, which was expected to be soon, before a referral was made.

56. At their meeting on 29 January, Officer I discussed other options that would be available to the man after he was sentenced (depending on the length of sentence) and gave further information about Lancaster Castle's 12 steps programme. Officer I told the investigator that the man was adamant that he wanted to "progress and always stressed the point he wanted to address his drug using behaviour". He saw a move to Lancaster Castle as a way of helping him stay out of prison and "make his family proud of him".

57. The man returned to court on the morning of 30 January and was told to return on 27 February to be sentenced. He was remanded back into custody and returned to the prison later that afternoon. He was examined by reception healthcare staff who reported no concerns.

58. Later that day the police faxed a form ("Police request for the production of a prisoner") to the prison. The form stated that the man was to be arrested for the offence of conspiracy to commit robbery, and the police wanted to interview him about the offence. The police intended to collect him from the prison at 9.00am on Monday 9 February and take him to the police station. He would be interviewed and returned to prison on the same day.

59. The prison's Safer Custody officer described the normal procedure on receipt of a production form from the police:

> Firstly the Police Liaison Officer (PLO) at the prison would be informed that a police division wished to have a prisoner produced to be interviewed about further offences.
>
> The PLO would then submit the application to the Governor for consideration as to whether the interview should be conducted outside the prison.
>
> The authorisation would be communicated to the prison's Custody Office and the date entered into the diary.
>
> Lastly the prisoner should be informed of the intention of the police to interview him.

60. The investigator was told that due to time constraints, the prisoner does not see the production order because of all the channels the document has to be passed through before being authorised.

61. Authorisation for the man to be released to the police was granted on 5 February. There is no entry on his wing history sheet to show that he was told of the police request.

62. Officer M said that she recalled the man returning from court where he had been told about the possibility of further charges. She spoke to him for about ten minutes, which was not unusual as she spoke with him daily. He did not disclose what the charges related to but did say that it had come as a surprise. Officer M told my investigator that he did not appear depressed nor was his mood low. He was keen to get on with his cleaning duties for the day. She saw him later that evening working on the servery and thought that he appeared normal. He was "having a laugh and a joke with the lads".

63. At interview with the investigator, the man's cell mate said that he had shared a cell with the man for four months and had known him beforehand. They shared a mutual interest in football. He said that the man was a "different man" after returning from court and being told about further charges relating to conspiracy

to rob. He denied committing the offence and did not want to talk to him about it. The man's cell mate said that the man's mood appeared to have changed and they talked less than before. He thought that he "wanted space" and did not pursue the matter with him.

64. During the next week, there were no concerns noted in his wing history sheet.

Events of Friday 6 – 7 February

65. On the afternoon of Friday 6 February, Officer I told the man that he had been cleared to transfer to Lancaster Castle. He gave him a self assessment questionnaire to complete and told him that he would collect it on Monday 9 February to forward to Lancaster Castle. Officer I raised no concerns and noted that "on a scale of 1 -10, he (the man) said his motivation to change was 10/10". He told the man that it was likely that his transfer would take place soon after he was sentenced.

66. At the weekend, prisoners are normally allowed out of their cells between 8.30am - 8.45am. On 7 February, between 9.00am and 9.30am, the man and his cell mate went to the VTU section on the wing for a routine drugs test. Both tested negative and Officer N and Officer K told my investigator that they had no concerns about the man.

67. Cleaners are required only to empty the bins on the landings on weekends and take them to the outside bins at around 10.00am. The man carried out his duties as usual on Saturday, and then had a period of association until the meals arrived for the servery shortly before midday.

68. The man went to the servery at lunch time. Officer M said that at first he was a little quiet. However as time passed and he continued to serve food, he began to be his normal self and she noticed him laughing and joking with other prisoners and herself. He also helped himself to extra food as cleaners are permitted to do.

69. The man told Officer M that he had asked another prisoner to cover his servery shift that afternoon because he was expecting a visit. He returned from the visit hall around 3.45pm and met Officer M on the landing. She asked how his visit had gone and he said his friend had not turned up. (The man did not seem to be disappointed that his friend had not turned up for his visit.) As usual he asked Officer M for a newspaper, and was told that it had already been given to his cell mate. Their conversation ended by Officer M saying she would see him in about 30 minutes at 4.15pm for his work in the servery for the evening meal.
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70. His cell mate said that the man told him that his friend had not turned up for his visit. Shortly afterwards at around 4.05pm, Officer M went to see the man and they stood talking at the entrance to his cell for around four minutes. Although Officer M could not recall the exact content of their conversation, she believed she had gone to check that he had received his newspaper. The man gave her no cause to believe that he was contemplating harming himself.

71. A short time later, the man asked his cell mate (and another prisoner who was in their cell) to leave so that he could use the toilet. His cell mate said this was a normal request from the man. He always wanted privacy when he used the toilet, and would lock the cell door from the inside. (Prisoners have keys to their cell and can lock the cell from the inside, although it can be overridden by staff.)

72. His cell mate and the other prisoner left the cell and went on to the landing next to the pool table, which was only yards away from the doorway of the cell. It was association time, and some minutes later, his cell mate realised that he had not yet come out of the cell. He initially believed that, as the man was due to start work very soon on the servery, he was probably changing into his uniform. As minutes passed, his cell mate began became suspicious. He approached the cell and looked through the observation panel. He could not see the man and thought he must still be in the toilet. (The toilet area is concealed from view when looking through the observation panel.)

73. A short time later, Officer M shouted for the servery workers to go check the food that had arrived. She did not realise until around 4.35pm that the man had not arrived. Officer M asked some of the other servery workers if they knew where he was. No one knew his whereabouts but said they were able to cope without him.

74. Officer M continued supervising the servery, expecting the man to arrive soon. Officer O told the investigator that he also worked on B wing and knew the man. He helped Officer M supervise the servery and stood monitoring the prisoners queuing for their dinner.

75. Around 15 minutes after the man's cell mate left the cell, he began to worry that something was wrong. He asked Officer O if the privacy lock could be opened on the cell door. Officer O explained that prisoners have keys to their cell and can lock the door from the inside. He said it was normal that prisoners would sometimes ask staff "to take their privacy locks off". Officer O walked across the landing and took the privacy lock off the cell. He then walked back to continue supervising the servery.

76. The man's cell mate went into the cell and found the toilet door closed. He told the investigator that he "knew what he was going to find" when he opened it. Within ten seconds of Officer O unlocking the door, the man's cell mate ran out screaming. Officer O then ran into the cell toilet area where he saw the man hanging from the bathroom rails, with a bed sheet round his neck. Officer P, who had also heard the screams, followed directly behind.

77. Officers K and N were on the outer B wing (first landing) servery area and both heard a noise which Officer K described as a "loud wailing". Unsure of the noise both officers immediately left the servery and ran to the wing to see what was going on. They asked other prisoners if they knew but none did. As they neared the source of the noise Officer O ran past them and into the man's cell. Both officers followed him in.

78. Officer P quickly supported the man's body whilst Officer O shouted for more assistance. Officer P told my investigator that he held the man in one arm, and used his fish knife with the other to cut the ligature. Officers O, who had now returned, helped Officer P place the man on the floor. As there was very little space in the toilet area, the officers moved the man into the main cell. Officer N saw the man's cell mate on the landing outside. He was in shock and had his hands over his face. Officer N also went into the cell.

79. Officer M also heard the man's cell mate and made her way to the wing landing, where she saw an officer running into the man's cell. She helped Officers P and O pull the man into the cell from the toilet area and checked him for signs of life. He was unable to find a pulse and commenced cardio pulmonary resuscitation (CPR). Although his first aid certificate had expired by about a year, he told the investigator at interview that he felt confident about administering CPR.

80. Officer N radioed (recorded on the time log as at 4.55pm) the Emergency Control Room (ECR) to request "Hotel One" (emergency healthcare response) and then assisted Officer O administer chest compressions. Officer K carried out mouth to mouth resuscitation, whilst Officer M continued to check the man for signs of life.

81. Principal Officer (PO) Q was the orderly officer in charge of the prison. He told my investigator that at approximately 4.55pm, he responded to a radio call for Hotel One. Hotel One was asked to attend B wing as a Priority One emergency call. He arrived and found staff carrying out CPR, after finding the man hanging in his cell.

82. At interview with the investigator, Registered General Nurse (RGN) R said she was on duty in healthcare and responded to the radio call at 4.55pm for Hotel One, Priority One. She contacted the Emergency Control Room (ECR) and said that she would go to the incident. She asked for further details of the emergency but was only told "'Hotel 1 to attend Bravo wing, Priority 1 immediately". As she made her way to B Wing, Nurse R said she was delayed slightly because the electronic gate at F Wing was locked. The ECR was contacted by radio and immediately released the lock. Registered Mental Health Nurse (RMN) T, who was with Nurse R, also went to B wing, collecting the emergency bag from the healthcare unit en-route.

83. PO Q deployed another officer to be responsible whilst he went back to the Centre office (which is above B wing) to ensure that an ambulance had been called and the relevant contingency plans had been put into operation. He asked for more staff to go to the wing to help lock prisoners into their cells, bringing the evening association period to an end.

84. The nurses arrived on B wing (outer) at 5.00pm and Nurse T described lots of prisoners on the milling around on the landing. When the nurses reached the man's cell, they immediately relieved the staff carrying out CPR, and checked for any signs of life. Nurse R said that the man did not respond, his pupils were

fixed and he was cold. She inserted an airway into his mouth and along with Nurse T, continued CPR (at a ratio of 30 compressions to two breaths).

85. Other staff arrived and helped lock the prisoners in their cells. Officer M, aware that the man's cell mate was upset, arranged for a Listener to sit with him in a cell.

86. At interview with the investigator, Nurse T said that they had not brought the defibrillator from healthcare because they were unaware of the type of emergency. However, soon after they arrived, Nurse R radioed for it to be collected from healthcare, and it arrived within minutes. Along with the defibrillator, CPR was continued until the paramedic crew arrived at 5.11pm. They were given an update of the situation, assessed the man and decided to transfer him to hospital. CPR continued in the back of the ambulance en-route. The man's cell was sealed after he was taken to the hospital.

87. As the paramedics continued to try to revive the man, PO Q arranged for Officer S to accompany him in the back of the ambulance. Officer S helped the paramedic try to resuscitate the man on their ten minute journey to the hospital. As soon as they arrived, the man was taken into the Accident and Emergency unit where doctors and nurses continued to try to revive him. A short time afterwards (at approximately 5.51pm), the hospital doctor informed Officer S that the man had been pronounced dead. Officer S immediately telephoned the prison to inform them and waited for transport to take him back to the prison.

After the man's death

88. PO Q said that, as soon as he was informed of the man's death, he continued to implement the death in custody contingency plans by contacting the relevant agencies, including the police. Prison staff who responded to the emergency were offered support from senior management and the care team. The man's cell mate described the staff response as "amazing" and said they acted quickly to try and resuscitate the man. He also welcomed the support he received from staff afterwards also.

89. PO Q held a hot debrief around 7.00pm. All staff who had any involvement when the man was discovered were invited to attend and raise any issues. Two issues were reported. The first related to the healthcare staff who thought they were delayed coming through from F wing because the electronic gate was locked. PO Q said he was aware of this at the time and immediately contacted the Emergency Control Room (ECR) who released the gate. This was confirmed by entries made in the Incident Log.

90. The other issue raised at the hot debrief was that healthcare staff, did not have a clear route through to the man's cell. PO Q said that it was association time and lots of prisoners were out on the wing. The staff who were on the wing (around five in total) had gone to the man's cell and were all on one part of the wing. Other staff had been asked to go to the wing to help and quickly to lock prisoners back into their cells. PO Q said that the wing houses around 150 prisoners. Staff said that no suicide note was found in the man's cell.

91. Father U and Father V were appointed as the prison Family Liaison Officers (FLOs). They arrived at the man's mother's house around 7.15pm to inform her, as his listed next of kin, of his death. Trevor's father and sister were also present. All relevant details were passed onto them, and they were taken by the FLOs to the hospital to identify the man.

92. The next day (Sunday), a unit meeting was held on B wing where prisoners were offered support and invited to report any concerns.

93. Over the next few days, the FLOs maintained contact with the man's family. Financial assistance towards the cost of the funeral was offered and a condolence letter was passed onto the family on behalf of the Governor and all the staff at the prison.

94. The man's funeral was held on 20 February and representatives from the prison attended. Prisoners who knew him organised a collection for flowers and raised over £300. His personal belongings were returned to his family the following week.

95. A Critical Debrief meeting was held two weeks after the man's death. Despite inviting all the staff who had some involvement on the day of the man's death, only Officers O and M attended. Officer M said she had to arrange for a member of staff to cover her absence on the wing whilst she attended the meeting. She felt that it was unfortunate that more staff could not attend, especially as she benefited from her attendance.

Post mortem

96. The post mortem results confirmed the cause of the man's death was hanging. The toxicology report revealed that he had not taken any illegal substances or alcohol.

ISSUES

Clinical care

97. The clinical review notes that the man's detoxification programme and support was carried out well, was considerate and targeted to his individual needs. He gave no "direct warning of any deterioration in his mental health or self harm ideation".

98. The attempt to resuscitate the man was described by the reviewer as delivered in an appropriate manner by officers and nursing staff. The reviewer judged that the delay of five minutes before healthcare staff to arrived at the cell was unlikely to have affected the outcome.

99. However, the emergency call to alert healthcare staff did not give details of the incident they were attending. Although the emergency bag was taken, Nurse T said that the defibrillator machine was not included because they unaware of the nature of the incident. As soon as they arrived at the cell, they asked for the defibrillator to be collected from the healthcare unit.

100. The Resuscitation Council UK reports that early defibrillation is considered an important aid to successful resuscitation. Although the defibrillator was quickly brought to the cell after it was requested, staff should ensure that they give adequate information over the radio when calling for assistance, which would help healthcare staff bring the right equipment.

101. The clinical reviewer notes that many members of the public have been appropriately trained to use automated defibrillation devices. Defibrillators can be used safely and effectively by untrained people well. As the advice on resuscitation emphasises the need to use a defibrillator as early as possible, one should be brought to the cell on every Priority One call.

    The Governor and Head of Healthcare should consider providing greater access and training to the defibrillators within the prison.

Further police enquiries

102. The man's family asked after his death whether he was aware that he was to be produced at the police station as it might have affected his mood. The investigator found no evidence to suggest that he knew he was to be taken to the police station on Monday 9 February. Although his cell mate confirmed that his mood changed after he was told at court that he might face further charges, he did not know if the man knew about the police production notification, which was authorised two days before his death. Nothing was noted on his prison records about his police production and it is unclear when he would have been informed.

103. The investigator was told that because of the short timescales the prison tends to get upon receipt of a production order, prisoners are unlikely to receive the notification document. Nonetheless, it seems the process would benefit from

having a clear audit trail, which includes when and how a prisoner is notified of such requests from the police.

104. It seems however that any concerns which the man might have had about being interviewed by the police were not apparent to staff. He was seen by his CARAT officer the day before his death, where he described his motivation to change as high. Wing staff who spoke regularly with him, including on the day of his death, also said that he gave no indication of intending to harm himself.

The Governor should review the process of police production orders and ensure that a clear audit trail is shown and information is delivered to all parties, including the prisoner, in a timely manner.

First aid training

105. Two of the officers who arrived at the man's cell reacted quickly to try to resuscitate him. They did this confidently even though their first aid certificates had expired. The Ombudsman has recommended in other investigations that first aid training should be provided for all staff in contact with prisoners. Although sadly it would not have made a difference in this case, I suggest that basic life support and first aid training should be reviewed for frontline staff to ensure that they have up to date resuscitation qualifications.

The Governor should review the need for first aid or basic life support training for staff on frontline duties, including refresher training when appropriate.

Critical Debrief meeting

106. A critical debrief seeks to give the staff the opportunity to understand a serious incident in greater detail, review their thoughts and feelings and normalise the reactions that some people experience after a traumatic incident. Unfortunately very few staff attended the debrief, and although not mandatory, staff should be reminded of its importance and encouraged to attend. Managers should encourage staff to attend debrief meetings by making advance arrangements to cover their duties.

CCTV footage and telephone transcripts

107. CCTV and telephone transcript data was passed onto the police immediately after the man's death. No copies were made for the investigator and he subsequently had had difficulty in trying to obtain these pieces of information. It would be useful if the prison could ensure it keeps copies of any CCTV and telephone transcript information as both are considered useful pieces of evidence.

The Governor should ensure that following a death in custody the security department keeps master copies of any CCTV and telephone transcript data.

CONCLUSION

108. The man arrived at Manchester and quickly set about addressing his substance misuse. He was successful and his regular contact with staff showed that he wanted to succeed and have a better life. His behaviour did not change significantly during his stay and certainly not to the extent that allowed any staff, to notice that he might harm himself. However, for what ever reason, he made the decision to take his life. The catalyst for his mood change appears to be because of the prospect of having to face further charges and ultimately an extended time in custody. He had never harmed himself before and I do not believe that prison staff should reasonable have expected him to do so on this occasion.

109. In general, I believe that the man's cell mate and prison staff responded quickly to the emergency.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should consider providing greater access and training to the defibrillators within the prison.

   The Prison Service has accepted this recommendation.

2. The Governor should review the process of police production orders and ensure that a clear audit trail is shown and information is delivered to all parties, including the prisoner, in a timely manner.

   The Prison Service has accepted this recommendation.

3. The Governor should review the need for first aid or basic life support training for staff on frontline duties, including refresher training when appropriate.

   The Prison Service has accepted this recommendation.

4. The Governor should ensure that following a death in custody the security department keeps master copies of any CCTV and telephone transcript data.

   The Prison Service has yet to respond on whether they have or have not accepted this recommendation.