

**Investigation into the death of a man
whilst in the custody of HMP Manchester
in April 2010**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

January 2011

This is the report of an investigation into the death of the man. The man was found hanging in his cell at HMP Manchester on 25 April 2010 and was pronounced dead by doctors at the North Manchester General Hospital shortly afterwards. He had been in custody for about six months. The man was 45 years old.

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, the clinical reviewer was asked by NHS Manchester to review the man's clinical care, and I am grateful for his contribution to the investigation. I also thank the Governor of Manchester and his staff for their participation in the investigation.

Having had his licence revoked on 1 September 2009, for an alleged offence of aggravated burglary, the man was remanded back into the custody of HMP Manchester. He appeared in court on 16 April 2010 and was committed to trial at Manchester Crown Court on 2 July.

On 25 April, the man made a large number of telephone calls to his partner in which he made it clear that he believed their relationship was breaking down. He told his partner that he had made a noose and suggested that he intended to use it. His last telephone call to his girlfriend was at 3.58pm, after which he returned to his cell. She did not report any concerns to the prison and the calls were not monitored by staff. He was alone as his cellmate was at work. The evening roll check commenced about 4.55pm. When the man's cell was checked, he was discovered hanging in his cell. The man had given no indication to staff or other prisoners that he intended to harm himself.

My report includes four recommendations, all related to healthcare issues.

The 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.

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SUMMARY

Following an allegation of robbery, on 1 September 2009, the man's licence was revoked and he was returned to HMP Manchester. He had been released on licence from Manchester only three weeks earlier.

The man was an experienced prisoner and, although frustrated at being back in custody, he soon settled into the prison regime. After his arrival at Manchester, he displayed no signs of wanting to harm himself. The man did suffer from back pain and received daily medication to combat this.

Whilst the man waited to see whether he was to be charged by the police for the offence, he took up employment within the prison. Staff regarded him as a good and well mannered prisoner who gave them no cause for concern and who attended work regularly.

In a meeting in March 2010, the man told his offender supervisor that he was experiencing flashbacks and not sleeping well. He attributed this to a particular event in his childhood. He told the officer he had previously sought counselling and wished to start this again. The man was also concerned about his relationship with his girlfriend and the impact if he received a long sentence. The officer agreed to look into various options for counselling.

On 25 April, The man spent most of the day in his cell alone, apart from an hour at lunch when his cellmate returned from work. His cellmate had no concerns about the man while he was with him. The man made numerous telephone calls to his girlfriend that afternoon. The majority were unanswered although he left voicemail messages on a few occasions. When the man did manage to speak to his girlfriend he said he thought she was seeing someone else and that their relationship had come to an end. He was not happy and told her he had made a noose and intended to take his life. The man made his last telephone call to his girlfriend at 3.58pm.

At around 4.55pm, the evening roll check was conducted. When the man's cell was checked, he was found hanging by a ligature from the window in his cell. 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. The man was subsequently taken to hospital where attempts to resuscitate him failed. He was pronounced dead at 5.54pm by the hospital doctor.

My report includes four recommendations, all relating to healthcare issues. They include a recommendation about first aid training for front line staff, which was raised in a previous investigation carried out at Manchester.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened by one of the Ombudsman's investigators on 29 April 2010 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, one prisoner came forward to be interviewed.
2. One of the Ombudsman's investigators also visited all parts of the prison including the wing where the man lived, and met the prison's liaison officer.
3. The man's prison records, including his medical record, were made available to the Ombudsman's investigator during his initial visit to the prison. A full set of documents were provided, already clearly filed, which he found helpful. Additional documents were made available when he returned to conduct interviews.
4. A clinical review of the man's medical care was commissioned from NHS Manchester. I am grateful to the clinical reviewer for a thorough review which highlights a number of recommendations and good practice. The clinical reviewer interviewed prison healthcare staff and also reviewed transcripts of interviews undertaken by the one of the Ombudsman's investigator. This report will be shared with the Primary Care Trust.
5. One of the Ombudsman's Family Liaison Officers contacted the man's mother and sister to inform them of the investigation and give them the opportunity to raise any questions or concerns about the care the man received. The man's family raised the issues below. I hope my report provides them with a better understanding of the events prior to his death.
 - The family said that when the man was arrested he was taken to a police station where it was alleged that he had attempted to take his life. The Ombudsman's investigator explained that such information should be passed from the police station to the prison with the man and such a significant event should have been recorded on the paperwork. Nothing to this effect was detailed on the man's prison records.
 - The family said they were told that the man's medication had been stopped. The prison said that it had not been stopped but was altered so that he received it in the evening rather than the morning. This matter is addressed later in my report.
 - They had also been informed that the man had been involved in an altercation whereby he ended up "black and blue and in the segregation unit". The family wanted to know if there was any truth in this. From reviewing the man's prison records and interviewing staff, no evidence could be found relating to an incident of this nature.
 - The family wished to know more about why the man was recalled to prison.

- After the man's death, letters were found in his cell which were taken by the police and the family were keen to know more about these. The Ombudsman's investigator is still awaiting information from the police on this matter.

BACKGROUND

HMP Manchester

6. 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.
7. 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. 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 Alcoholics Anonymous, drug treatment courses and a more relaxed regime.
8. At the time of writing this report, the man's death was the second apparently self inflicted death to occur at Manchester in 2010 and the 20th such death since the Ombudsman took over responsibility for investigating all deaths in prisons in 2004.

Her Majesty's Chief Inspector of Prisons

9. The most recent inspection by Her Majesty's Chief Inspector of Prisons was an announced full inspection in July 2009. Published in December 2009, her comments included:

“... Manchester is a complex and large prison, which needs to manage a varied population, including those involved in gang activity. It is commendable that it has managed to retain its local prison focus, and to provide purposeful activity for a large number of prisoners, while holding securely its category A prisoners. The focus and direction of its resettlement work needs attention: in particular, the services for drug and alcohol users. More fundamentally, HMP Manchester managers need to explore and remedy the lack of trust between some staff and prisoners, building on the strong relationships in some parts of the prison to ensure that interactions are both appropriate and positive.”

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

10. CARATs is designed to meet the non-clinical treatment needs of the majority of prisoners with substance misuse problems. CARATs is the foundation of the drug treatment framework and is available in every custodial establishment.

Cut down tools

11. Ligature knives are designed to cut ligatures safely and are carried by all officers and healthcare staff in contact with prisoners.

Emergency response codes

12. 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.
13. Healthcare staff have five emergency bags located around the prison. They contain life support equipment which includes airways, ambu bags (a 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 with the authority of a doctor.

Listeners

14. 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.

OASys

15. OASys (Offender Assessment System) is a system developed jointly by the Prison and Probation Services. It is structured to help practitioners assess how likely an offender is to re-offend and the seriousness of any potential offence. It assesses the risk of harm an offender poses to themselves and others.

Recall process

16. A sentenced prisoner who is released early has to abide by licence conditions. Should there be a breach of any of these conditions, they are liable to be recalled to prison.

Reception and induction

17. A Cell Sharing Risk Assessment (CSRA) is opened by a reception officer who completes the basic details. The form is handed to the First Night Centre staff who conduct a confidential interview. The document is then passed to healthcare staff. The CSRA is intended to provide consistent and continuing risk assessment regarding sharing cells. While primarily used to assess cell sharing, it also includes other occasions when a cell may be shared, for example if a prisoner requests the assistance of a Listener.
18. 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 from another prison, his past record would arrive with him. All prisoners will also have a Person Escort Record (PER) form (a document used when escorting a prisoner between prisons, court and police stations) which will include relevant information such as risk to others and self.

19. 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.
20. 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 a more appropriate wing 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

21. 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

22. The man was born and brought up in the Wythenshawe area of Manchester by his mother and father. He was the middle child of three. He became involved in offending which led to a number of periods in prison. In spite of this, the man left school with six 'O' levels. He had numerous convictions dating back to 1980. He also misused drugs and alcohol.
23. In June 1995, the man was convicted at Manchester Crown Court for robbery and possessing a firearm. He was given an 11 year custodial sentence. He was released on temporary licence (ROTL) on 17 October 2000 and then recalled back to prison on two occasions (November 2001 and May 2002) because of a breach of his licence conditions.
24. Having spent a number of years in and out of prison, the man was released from HMP Sudbury on ROTL to an approved premises (formerly known as bail and/or probation hostels) on 22 April 2008. He was recalled to HMP Ranby the next day after breaking one of the terms of his licence by drinking alcohol. He had several successful ROTLs after this date until he was released on parole on 2 December. One of the conditions of parole was that he must reside in an approved premises.
25. On 12 December, the man was involved in an altercation with the police during which he became abusive. He was arrested under the Public Disorder Act and bailed to appear at Manchester City Magistrates' Court on 23 February 2009. The man was released from the police station at 10.30pm with instructions to return immediately to the approved premises. However, he failed to return and despite attempts by probation staff to contact him, his whereabouts were unknown. Staff therefore began the process to revoke his licence.

The man's arrival at Manchester

26. On 26 March, the man was arrested and returned to HMP Manchester, where he went through the normal reception process. Officer A explained the prison's first night in custody and assessment booklet to the man to assess any concerns or immediate needs he might have. No concerns were raised. The Cell Sharing Risk Assessment (CSRA) was completed and identified the man as a "Low risk". He told staff that he had previously abused drugs. He was offered refreshments and made a telephone call to his girlfriend.
27. Following this, the man attended a healthcare screening with the duty healthcare assistant (HCA). He declared that he had a history of back pain and had taken ranitidine (to treat ulcers in the stomach and intestines) and tramadol (to treat moderate to moderately severe pain). The man said he had seen a doctor in the last few months and been prescribed lansoprazole (to treat stomach ulcers). The HCA noted that the man had no current thoughts of wanting to harm himself and was fit for normal location and work.

28. Afterwards, the man was examined by the prison doctor. He was relaxed and displayed no signs of distress or thoughts of self harm. The doctor recorded that the man suffered from back pain described as “herniation of disc” (a tear in the outer spinal disc which allows the soft, inner disc to bulge through) for which he was receiving the medication noted by the HCA. The doctor recorded that he would need to check the prescription of tramadol with the man’s doctor before he would prescribe it. Until this check was made, he prescribed the man with paracetamol and lansoprazole.
29. The man was located onto the induction unit and took part in his prison induction over the next few days. He was seen by members of staff from the chaplaincy, education and housing teams and also received a second health screening.
30. On 22 April, the man was located onto a normal residential wing and soon took a job as a cleaner on the wing. Thereafter, he settled into prison regime.
31. The man continued to complain of back pain and was seen several times by healthcare staff. He insisted that he had been prescribed tramadol before coming into prison. His community doctor confirmed that he was last prescribed tramadol in December 2008. This was a one-off occurrence and had not been repeated since. The man was referred for physiotherapy and had a number of sessions aimed at alleviating his pain. He was also prescribed co-codamol (a pain killer).
32. On 1 and 9 June, the man was seen by the prison doctor. He said that his wife had had a miscarriage and had attempted suicide. He complained of anxiety, low mood and poor sleeping pattern. He was still experiencing back pain despite the physiotherapy sessions. He was prescribed a one off short term use of zopiclone (a sleeping tablet). The doctor also changed his co-codamol medication to tramadol (50mg) and told the man that he should continue with physiotherapy. The dosage of tramadol was later increased to a daily dosage of 150mg. (There was no further mention of the man’s wife in his prison records.)
33. The public disorder charges brought against the man which resulted in his recall to prison were later dropped by the police. He was therefore released from prison, into approved premises, on 11 August.
34. However, within three weeks of his release from prison, the man’s licence was revoked again. On 31 August, he was arrested in relation to an incident of aggravated burglary and returned to Manchester on 1 September. He repeated the normal prison reception screening process.
35. The man’s healthcare screening was conducted by the HCA. The HCA noted that the man’s previous medication as Zamadol 300mg daily, lanzoprazol 30mg daily and co-codamol. The man admitted drinking 24 units of alcohol in the previous week and said that he had no thoughts of wanting to harm himself. He told the HCA he had been seen in the last few months by a doctor for back pain and stomach ulcers. The man also declared that he was receiving mitrazapine

15mg daily (normally taken for depression) for mental health problems, although had not had any for four months. An automatic referral to the Mental Health In-Reach team was made by the HCA as the man had previously been prescribed medication for a mental disorder.

36. A CSRA was also completed in the reception area. The HCA and Officer B decided that the man's risk was "High" as he had previously abused alcohol and drugs. It was noted on the CSRA form that the man "was on an 11 yrs sentence stated he was always single cell. States he bit the nose of his cellmate in (1997), though old CSRA ..."
37. The man was located on to G wing, the induction unit. His first night assessment was completed by Officer C who indicated that he could undertake the "fast tracked" induction programme because he had spent a previous period in custody at Manchester. During his assessment, the man said he had no current thoughts of wanting to harm himself. The man also answered "No" to the following questions:
 - Do you have any medical conditions that you need to make us aware of?
 - Have you been given any medical treatment in reception?
 - Are you expecting to receive any further treatment today?
38. As a consequence of the man's back pain and stomach ulcer, he was examined that evening by prison doctor A and prescribed lansoprazole 30mg, tramadol hydrochloride modified release capsules 100mg (twice daily), an increase of 50mg a day from the dose prescribed three weeks earlier, and Gaviscon chewable tablets. The doctor made no reference to the man being prescribed antidepressants in the past, any reason for the prescription or any exploration of his current symptoms.
39. Within the man's prison records was an OASys document dated 1 September. The man disclosed that he was very depressed about his recall to prison and had suicidal thoughts, but had not told anyone at the prison about how he felt. The document indicates that the man disclosed this on 12 August. The document indicated that this information was to be passed onto the prison. When interviewed by the clinical reviewer, the HCA indicated that he had not been made aware of any concerns about a risk of suicide in any accompanying documents when the man was received into Manchester on 1 September.
40. At interview with the investigator, Community Psychiatric Nurse (CPN) said he received the man's mental health referral on 2 September. As the man had not been examined by a doctor regarding his mental health needs, the CPN had to refer the man back to the doctor for a primary assessment. The CPN had no direct contact with the man.
41. The following day, the man attended his secondary health screen assessment with Nurse A. She noted his previous medication and that he had a history of depression. She recorded that no further action needed to be taken.

42. As the man's CSRA was assessed as "High", a CSRA review was conducted on 6 September by Officer A. The man was interviewed and said that he was frustrated at being back in prison. He felt that his mood swings were very unpredictable but would try to work towards being able to share accommodation. A further review was completed on 2 November by SO A and the man's CSRA was reduced to "Medium" risk.
43. Following the man's recall to prison, Officer D was appointed as his offender supervisor. Under this arrangement, he would meet the man at least monthly, to make sure he was alright. This would be supplemented with further meetings as and when any issues needed to be addressed.
44. At interview, Officer D said that the man had further charges against him pending and, so there were few offender rehabilitation programmes that he could undertake. This was because it was not known how long the police investigation would take or how long he would be in prison. Officer D explained that his role was to ensure the man was well, and persuade him to use his time by attending work and workshops.
45. Officer D said it took a few months to build a rapport with the man as he was quite "guarded". However after this period, he was chatty and demonstrated that he was an intelligent man who had high hopes of doing things. The man told Officer D that, when he was released from prison, he wanted to work with young people to stop them getting into the position he found himself in.
46. There is an entry on the man's medical record on 29 December. It stated that healthcare staff had had a conversation with staff at HMP Sudbury. It was confirmed that the man had been prescribed tramadol when he was in custody there and was still taking the medication when he left in October 2008. There was a further note of a telephone call to the Alexandra Practice doctor's surgery that day. It confirmed that he had been prescribed tramadol 150mg daily in August 2009 and had left the practice in November 2009, (probably because he was in prison custody).
47. From November to February 2010, Officer D met the man regularly. He settled into prison regime, moved to a number of different wings and later took on the role of a cleaner. He went on to be transferred to B wing where he was employed as a kitchen worker. Officer D was deployed to search kitchen/workshop workers at lunch times. He therefore came into contact with the man at least three times a week and often had a quick chat with him about his well being.
48. Following the man's move to B wing, his tramadol prescription was reviewed. The doctor noted that individuals who were on medications such as tramadol (which could sometimes cause drowsiness) would not normally work in environments such as the kitchen, because the work involved heavy lifting and handling of hot plates. The man told the doctor that his main task was washing up. Nonetheless, the doctor explained to him that he would need to come off tramadol and they agreed this would be replaced by co-codamol from 3 March and reviewed at the end of the month. The man told the doctor that he had

moved to a new cell where the mattresses had not been replaced and he found that this was affecting his back.

49. At interview, Officer D said that as a B wing officer he had daily contact with the man. He described him as polite and well mannered and said he had no cause for concern. Officer D said that if other prisoners “behaved as well as the man there’d be very few problems in the prison”.
52. As a kitchen worker, the man normally worked three days a week, then had one day off, and then worked three days again. On weekdays, his shift started at 8.00am and he returned to the wing about 12.00pm. (Some prisoners remained in the kitchens to finish cooking the tea time meal.) The man never failed to attend work on his shift.
53. Officer F was the man’s personal officer. They met weekly and he was the man’s first port of call if he had any concerns. Officer F told the investigator that the man was a quiet man who raised no concerns to him. They had talked about the man applying for enhanced prisoner status under the Incentive and Earned Privileges scheme (IEP), and Officer F was looking into this. The man appeared to enjoy his work in the kitchen, especially as it meant he was out of his cell for majority of the day.
54. Officer D recalled that he had a meeting with the man on 7 March when he had seen him working in the kitchens and his mood appeared low. The meeting became very in-depth and lasted over an hour. The man disclosed that he was concerned about the outstanding charges against him which he believed were unfounded. He was due to have a meeting with the police in about two weeks time and the uncertainty was causing him some anxiety.
55. The man was also having problems sleeping and said he had experienced a number of “flashbacks”, which he said was related to being abused as a child. The man had difficulty trusting prison staff and speaking about this to Officer D was a big step for him. The man said he would not speak with any other person about it.
56. Officer D spoke to the man about the organisation called National Association for People Abused in Childhood (NAPAC, a charity based service that deals with people that have been abused as children) and they agreed that he would be referred. The Officer said he would look into the matter and get some information for the man. The man said that he had had previous contact with another similar charity organisation called Fire and Ice. They had provided support and he wondered if this could resume.
57. During their discussion, Officer D asked the man if he had any suicidal thoughts. The man said that he did not. He said he was glad that he had spoken to Officer D about his concerns and welcomed the idea of support from NAPAC. He was reminded about the services of the prison’s Listener scheme and, although the man said he would not use them, he did say he would contact the Samaritans by telephone if needed.

58. When asked if he had any further concerns, the man said that he was having issues with his mail. His girlfriend had told him that she had sent some letters to him at the prison, but he had not received them. The man was concerned that his mail was being monitored by the security department who were then withholding it from him. From previous conversations with the man, Officer D was aware of these concerns and had checked the prison's mail system. The man was not sure, however, that his girlfriend was actually sending him letters and believed he might be losing her. He was also anxious because, if charged with the offence he was recalled for, he might receive an Indeterminate Sentence for Public Protection (IPP). If this happened, the man felt it would be unfair on his girlfriend who would not know when he would be released from prison.
59. On the morning of 8 April, the man was seen by the prison doctor to review his ongoing back pain. He said that co-codamol made his back pain worse during the night but appreciated the dangers of taking tramadol and possibly feeling drowsy whilst working in the kitchens. He had now moved onto lighter kitchen duties. The doctor discussed the options with the man and they agreed that the doctor would prescribe tramadol again, to be taken at night. During the day, naproxen (used to reduce pain) and paracetamol could be taken. The man agreed to stop taking the medication if it made him feel drowsy. The doctor said they would try this for two weeks.
60. Officer D had another conversation with the man on 9 April. He informed him that he had checked the mail system and the man's mail was not being withheld by the security department. He informed him that the charity Fire and Ice no longer existed, but he had found some information on NAPAC which he would give to the man soon. NAPAC had a representative who attended the prison and Officer D was awaiting their contact details to arrange a meeting. He hoped to have the information in the next week.
61. On 16 April, The man appeared at Manchester City Magistrates' Court and was committed to trial at Manchester Crown Court on 2 July. On his return to Manchester, a health screening was conducted by Nurse B who recorded "Nil raised on return from Court". This indicated that no concerns were identified at this time.
62. The man's cellmate on B wing at Manchester. He had known him for about six months. At interview with the investigator, the man's cellmate said that in the weeks leading up to his death, the man's mood was low. The man told him this was because of family and girlfriend problems. He was aware that the man had had several arguments on the telephone with his girlfriend and she had not visited him on several occasions. He was also concerned about the length of sentence he might get, believing he might receive an IPP sentence, amounting to around ten years. The man had once said to the cellmate that if he was found guilty at court, he would "tie" himself up. However the cellmate had not believed that the man meant this literally and he (the cellmate) said he never thought he would take his life.

63. The man had also talked to the cellmate about his back pain. His medication had been changed but he still experienced bad pain which hindered his sleep. The man had complained about this to healthcare and his medication was changed again. The cellmate said that this occurred in the four weeks before the man's death.
64. On 20 April, the man asked Officer E to look into the matter of missing mail that he was expecting from his family. The mail had apparently been sent into the prison by recorded delivery. The man said that his mother was seriously ill and, although he was unhappy about this, said he was okay. Officer E offered him support and saw no signs that the man might want to harm himself.
65. Following the man's death, the prison's security department completed a number of reports about telephone calls made by the man between 21 April and 25 April. Prisoner telephone calls are recorded, as is normal across the prison estate, but they are not routinely listened to. The investigator was provided with a copy of the telephone calls.
66. On 21 April at 7.46pm, the man telephoned his girlfriend. She was supposed to have visited him in prison but said she did not come because she was scared of him. The man's response to this was "I'm glad, it makes it easy to do what I want to do". The man then spoke to his nephew at 7.56pm and said "feel like throwing a ring round my neck". He made a number of calls to his girlfriend which were unanswered. He left one message which said he loved her and she should not be scared of him.
67. The next day, 22 April, the man spoke again with his girlfriend. She told him that she was scared of him because he had threatened to bite her nose off on a visit. The man said he had been in the segregation unit for a week. (The investigator found no evidence to support this.) They argued over money and the man said he had thoughts about killing himself. The man next made a telephone call on 23 April to his girlfriend and said he was being bullied by staff. (There was no evidence of this allegation within the man's prison records.)
68. On Saturday 24 April, shortly after 4.00pm, Registered General Nurse (RGN) was working on A and B wing administering medication. At interview the nurse said that she recalled the man coming to the medication hatch to collect his tramadol. He appeared fine and took his medication, as normal, in front of her. Having confirmed with the nurse that he had a doctor's appointment booked for Monday to review his medication, the man said "see you tomorrow Miss", and returned to his cell. The nurse said she expected to see the man around the same time the next day to collect his medication.
69. During the weekends, prisoners who are rostered to work in the kitchens still attend work, preparing the meals for the day. Other prisoners are unlocked around 9.00am. It was not uncommon for prisoners to remain in their cells and have a lie in at the weekend. Some do get up around 9.30am as, for most of the day, prisoners are on "association" (when they can socialise outside their cell with other prisoners, use the telephones and showers). Between 11.30am and 12.00pm, lunch arrives on the wing and prisoners collect their food and

return to their cells. Cells are locked while staff have their lunch from around 12.30pm to 1.30pm. After this, prisoners are unlocked until around 5.00pm, dinner time. Once they have collected their dinner, prisoners are locked in their cells for the night.

25 April

70. On the morning of 25 April, the man remained in his cell as he was not required to work. His cellmate worked in the kitchens during the morning and returned as normal at lunch time. They collected their lunch at the same time and returned to their cell to eat it. The man then lay on his bed listening to music. During this time, the cellmate described the man's mood as "sound", meaning that he was fine.
71. After the lunch time period ended, the cell was unlocked for the man's cellmate to return to work. Around this time, the cellmate telephoned his girlfriend. She mentioned that she had had a conversation with the man's girlfriend, about her (the man's girlfriend) "boss" at work. She asked the cellmate to ask the man if he knew anything about it. The man's cellmate was unsure about content of the women's telephone conversation but spoke to the man about it before returning to work. The man raised no concerns with him and said he would telephone his girlfriend to find out what was going on. The man cellmate said he had no reason to believe that the man was upset about anything.
72. The prison's telephone log report showed that the man made 39 telephone calls on 25 April between 1.38pm and 3.58pm. Of these, 24 were to his girlfriend's mobile telephone. The majority of the calls lasted less than one minute and in many cases zero seconds, indicating that the man sometimes left messages on his girlfriend's answering machine and sometimes hung up. The security department's reports outlined the contents of the five telephone calls where the man either spoke to his girlfriend or left a message on her answering machine.
73. During the call that the man made to his girlfriend at 2.33pm, he left a message on her mobile telephone. He said he had taken the hint and was sorry about everything, wished her well. The man said he had "taken the hint that it's all over" and ends the call by saying goodbye.
74. The man telephoned his girlfriend again at 3.03pm. On this occasion she answered the telephone. He asked why she was not in when he had called earlier and questioned her about the telephone conversation with the man's cellmate's girlfriend. The man told her that he had left a goodbye message on her answering machine and asked if he should take the hint. He said he had made a noose and tried it out. His girlfriend asked him not to do this or she would contact the prison. The man asked her not to do so and changed the topic. His girlfriend asked him if he was going to do anything and again the man said he had tried the noose. His girlfriend answered that, if he had any intention of doing anything, he would not have told her about it. The call then ended. This telephone call lasted five minutes and 14 seconds.

75. Within two minutes (3.10pm), the man telephoned his girlfriend again. The call went straight to the answering machine and lasted for 17 seconds. He asked her to pick up the telephone. A minute later (recorded on telephone records as 3.11pm), the man called again. On this occasion, his girlfriend picked up the telephone and the man asked who she was with. She said she was at her friend's house and her boss was with her. The man was not happy and believed something was going on between them. His girlfriend denied this. The man said he had just tried the noose around his neck and that it would be better for her if he used it. His girlfriend begged him not to do anything. The man stated that "If you don't want me, I'll get on with it".
76. The man made a further 12 telephone calls to his girlfriend, all of which were unanswered. During the penultimate call, made at 3.56pm, he left a message. He said "you have turned your phone off then, think you're with Les. Its time for me to check out and check out I will. You sold me out for a geezer you work with, see ya". The man's last call was made at 3.58pm. He left no message, and ended the call after three seconds. It appears that the man then returned to his cell.
77. The man's cellmate returned from work about 4.45pm to find the cell door courtesy lock on (an internal lock on the door which prisoners can use such as when using the toilet). He said he looked through the door flap but could not see the man. He believed that the man was using the toilet and so, after waiting a short while, looked again into the cell. Having received no response, he decided to collect his dinner from downstairs. He knew that all the cells would be locked soon for the roll check and did not want to miss his dinner. When he returned to the landing he went straight to another prisoner's cell, two doors away, to borrow a newspaper. Whilst he was doing this, officers began to make their roll checks to confirm that all the prisoners are present.
78. At interview with the investigator, Officer G said he had been on duty on B wing all day. He had not had any significant contact with the man, although this was not unusual. Around 4.30pm, Officer G and Officer H were on the third landing, waiting for prisoners to collect their dinner and return to their cells. This lasted approximately 20 minutes. Both officers then began the roll check. Officer G went to the fourth landing to begin locking the cells, whilst Officer H remained and checked the cells on the third landing.
79. The man's cell (number 4-08) was about the third cell to be checked by Officer G. The courtesy lock was on, but staff keys over-ride this. He looked through the cell flap but could not see anybody in the cell or on the bed. Officer G initially thought he saw a T-shirt hanging up on the top left of the window and then realised that it looked like a person. He immediately went into the cell and found the man hanging from the window. He shouted for "staff" several times.
80. Although Officer G was not first aid trained, he described the man as looking grey and lifeless. He lifted the weight off the man's neck and used his ligature knife to cut the ligature, which was tied to the window. The man fell on top of

Officer G and both men fell to the floor. Officer G managed to stand up as Officer H arrived at the cell.

81. At interview, Officer H said he had only just begun his roll check on the third landing when he heard Officer G shout for staff. He ran to the fourth landing immediately. En-route, a prisoner said that Officer G was in cell number eight. Officer H went into the cell and saw the man on the floor. Officer G was standing at the rear of the cell to the right, with his ligature knife in his hand. The man's head was towards the cell door, his feet towards the far wall and he was lying on his side. Officer H saw a ligature made from a torn green bed sheet around the man's neck. He used his ligature knife to cut it off, finding that it had been wrapped twice around the man's neck. As he was doing this, Officer I arrived at the cell.
82. At interview with the investigator, Officer I said he was on the third landing when he noticed Officer H running to the fourth landing. Assuming that something must be wrong, he immediately followed him. He went into the man's cell seconds after Officer H and saw the man lying unconscious on the floor.
83. Officer I immediately pressed the general alarm on the landing to get further staff to assist. Having returned to the cell, Officer I saw "red, deep gouges" on the man's neck and realised that he had harmed himself. The three officers in the cell placed the man flat on his back. Officer H used his radio to contact the control room to request Hotel 1 (emergency call for healthcare) to come to the wing immediately. He explained that there was an unconscious prisoner with a ligature around his neck. Officer I and Officer H checked the man for any signs of life but could not find any. Officer I commenced cardio pulmonary resuscitation (CPR) by conducting chest compressions until two nurses from healthcare arrived.
84. Senior Officer (SO) B was in charge of B wing and was on the second landing when he heard the general alarm go off. He responded immediately and was directed to the man's cell. He arrived to see Officer H in the cell and Officer I carrying out CPR. SO B sent another member of staff to A wing to inform the nurse on duty at the treatment hatch, to try and get a quicker response. Although SO B was not CPR trained, he remained in the cell in case Officer H needed any assistance.
85. Principal Officer (PO) A, who was in charge of the prison, responded to the general alarm within a minute with her colleague PO B. As it was dinner time on B wing, a number of prisoners were out of their cells. She looked into the man's cell and saw that staff were carrying out CPR. The control room had already telephoned for an ambulance and healthcare were en route to the cell. Aware that the situation was being dealt with, PO A began to arrange for the prisoners to go back into their cells whilst checking on their welfare.
86. Having completed treatments for the day on B wing, the RGN moved to A wing. She was checking the medication sheets and realised that the man had not come to the hatch to collect his medication. Concerned that he would need his

pain killers, she telephoned the office on B wing to inform the staff to bring the man down. The telephone remained unanswered. Within seconds, she heard the general alarm ringing out.

87. Although Nurse C was unavailable to be interviewed, the investigator has seen her incident statement, which was made shortly after the man was discovered. Nurse C was working on C and D wing. She was carrying radio Hotel 1 which meant that he was the nurse required to respond first to any emergency calls. She had just completed treatments and was making her way back to the healthcare centre when the general alarm sounded. This was at 5.02pm. A message then came over the radio that Hotel 1 should attend cell B4-08. Nurse C made her way back to B wing and advised the control room that she had received the message and was en route.
88. In the meantime, the RGN was informed by an officer on A wing that it had just been announced over the radio that a prisoner was unconscious with a ligature on B wing. The RGN immediately made her way to the centre office on the second landing and collected the emergency medical bag, the defibrillator (a machine which can administer electric shocks to the heart) and the oxygen. She made her way to B wing.
89. Having intended to collect the emergency medical bag en route, Nurse C saw the RGN with it at the entrance to B wing. The nurses entered B wing together and made their way to cell B4-08. It took them approximately two minutes from hearing the general alarm to arrive at the cell (arriving at approximately 5.04pm). As they did they found CPR being administered and were quickly updated by the officers in the cell.
90. The RGN examined the man. He was not breathing and was unresponsive. His colour was pale, he was cyanosed (meaning his skin had turned a bluish-grey colour) and his pupils were fixed. The RGN took over the responsibility for the man's airway by inserting a guedel airway to ensure that it remained clear. She used a plastic mask to administer rescue breaths whilst Nurse C connected the ambu-bag to the oxygen and connected the defibrillator to the man. Nurse C took over cardiac massage from Officer I. The defibrillator was used to assess the man's heart rhythm and no shock was advised so the nurses continued CPR whilst awaiting the arrival of the ambulance.
91. A paramedic crew arrived at 5.13pm. They immediately connected their own defibrillator. The man remained in asystole (a state of no cardiac electrical activity), a non-shockable heart rhythm. The RGN continued to assist the paramedics whilst the man was lifted on to the paramedic's stretcher. CPR continued throughout and the man was taken to the ambulance. The paramedics attended to his airway whilst the RGN took over the chest compressions from Nurse C. When the paramedics were ready to make their way to North Manchester General Hospital, the nurse left the ambulance leaving the man in their care. The ambulance left the prison at 5.45pm. As is prison policy, two members of prison staff were selected to escort the man and the ambulance to the hospital.

92. Having returned to the man's cell to check that no medical equipment had been left behind, Nurse C noticed that the man had taken the blade out of a razor which was on his cupboard with a bag containing a number of naproxen tablets.
93. SO A and Officer J were selected to escort the man and the ambulance to the hospital. At interview, SO A said that when he arrived to carry out this function, the man was already in the ambulance. The paramedics and nursing staff were carrying out CPR. The paramedics continued with CPR en route to the North Manchester General Hospital.
94. On arrival at the hospital, the man was taken straight into the Accident and Emergency Department where resuscitation continued. However, at 5.54pm, the hospital doctor confirmed that the man had died. SO A immediately informed the prison.

After the man's death

95. As soon as the man's death was confirmed, the death in custody contingency plan was implemented by the duty Governor and Safer Custody Manager. All the relevant agencies, including the police, were contacted. Details of The man's next of kin were also located.
96. PO A held a hot debrief around 6.00pm. All the staff who had any involvement when the man was discovered were invited to attend and raise any issues. Support was offered from senior management and the care team.
97. The man's cellmate was shocked by the man's hanging and told staff that he never believed that the man would want to take his life. The man's cellmate was offered support from staff, healthcare and listeners.
98. The chaplain and Officer K (the Violence Reduction Coordinator) were appointed as the prison family liaison officers (FLOs). At interview with the investigator, Officer K said that they arrived at the man's mother's house around 9.00pm to inform her, as his listed next of kin, of his death. The man's two sisters were also present. The chaplain passed on all the available details about the circumstances surrounding the man's death and answered the questions put to him by the family as best he could. The family were also given the details of the coroner, who was responsible for the release of the man's body.
99. The FLOs maintained daily contact with the man's family. Financial assistance towards the cost of the funeral was offered and a condolence letter was passed to the family on behalf of the Governor and all the staff at the prison. The family were also offered a visit to the prison which was later accepted. The man's personal belongings were returned to his family.
100. Officer D had been on other duties and then a period of leave after his last meeting with the man on 7 April. He had gathered some information for him about NAPAC and, when he telephoned the wing on 26 April to speak with him, was informed of his death.

101. The man's funeral took place on 11 May. A memorial service was also held in the prison for staff and fellow prisoners on 14 May which was well attended.

ISSUES RAISED IN THE INVESTIGATION

Clinical care

Access to records

102. The clinical review was conducted by the clinical reviewer and makes 13 recommendations. None of these is thought likely to have had an influence on the man's death and I refer to those which are most pertinent to my investigation. The clinical review will also be shared with the Primary Care Trust.
103. The man underwent initial reception screening at appropriate times and the relevant procedures were followed. However, on both of the occasions that he was returned to custody at Manchester, neither screening led to his previous prison medical records or GP records being obtained. The clinical review provides a detailed recommendation in respect of this matter. I have summarised the main point below.

The Director of Healthcare in conjunction with the GP service at HMP Manchester should ensure that previous medical records are obtained, especially when they have been alerted to a pre-existing medical condition when a prisoner is received into custody. This should also include checking other data sources where self harm risks have been identified.

104. It is not clear whether the OASys documentation accompanied the man to Manchester or, if it did, whether it was specifically reviewed. The policy and strategy document for Manchester indicates that OASys, amongst other data sources, must be checked for risk to self information and this information passed to the wing manager. It was not clear from the documentation reviewed whether the OASys assessment was available when the man arrived at reception or whether those undertaking the reception process could access the form electronically. The recommendation I have made above covers my concerns in this area.

Mental health care

105. On the one occasion that the man complained of being low in mood, he was prescribed a sleeping tablet. He was not asked whether he had thought of wanting to harm himself. There is also no evidence to suggest that an assessment was completed to see whether he was suffering from depression or another disorder and no plan was made to review his problem at that time.
106. When the man was referred to the mental health in-reach team (MHIT), this was done in a timely fashion. However the MHIT had no direct contact with him and therefore no discussion took place about mental health problems or prescribed medications. The outcome of the referral was insufficient to determine whether the man did or did not have a mental health problem. The nurse did however refer the man back to the prison doctor which could have triggered a further

referral if necessary.

107. The clinical reviewer noted that, from his discussions with healthcare staff, that the system of triage had changed and included direct contact with the prisoner. The first contact the man had with a doctor should have included a basic history of why an antidepressant had been used and whether he had any current symptoms of depression.
108. In spite of this, the clinical reviewer felt that discipline and healthcare staff had a lot of contact with the man and it was unlikely that he would have been suffering from any significant degree of depression. There was no reason in the weeks prior to his death that healthcare staff might have been aware that he might want to harm himself. Nonetheless, it is important that information relating to a prisoners' mental well being is used effectively.

The Head of Healthcare should ensure the operational policy for the mental health in-reach team, refers to the circumstances in which information given by the patient should be cross-referenced with other sources, particularly where there is any mental disorder or treatment and doubt exists about accuracy, even if this means a delay in completing the assessment.

The man's back pain

109. The man complained of back pain throughout both his stays at Manchester. He was examined repeatedly and prescribed appropriate medication and physiotherapy. The clinical reviewer notes that he received a good level of care during his initial period at Manchester.
110. During the period September 2009 to April 2010, the man specifically requested tramadol to manage his back pain. The clinical reviewer notes that tramadol can lead to dependence with long-term use and its use should therefore be continually reviewed. Tramadol is also known to be a 'currency' within a prison and can be bought, sold and abused. On the man's reception in September 2009 he said that he was taking a dose double that which he had been prescribed three weeks earlier in the prison. In the experience of the clinical reviewer it is not unusual for this to happen in respect of prisoners with a history of drug misuse. Although the Manchester healthcare unit ascertained three months later what the man's previous prescription had been, the reasons for and length of treatment were not obtained. Access to his community GP medical records would have clarified this. The clinical reviewer further notes that the focus appeared to be on prescribing medication rather than considering alternative treatments or investigations.
111. The man's second period in custody was less well co-ordinated in respect of his treatment for his back pain. It was hampered by the absence of previous prison records or his community doctor. The clinical reviewer made the following recommendation.

The Head of Healthcare should use nationally or locally agreed guidelines or protocols to manage common conditions, including back pain, in line with practices in the community.

First aid training

112. All the staff reacted swiftly when the man was discovered and resuscitation was initiated. Two of the officers who arrived were not CPR trained, although they did assist. The Ombudsman has recommended in other investigations that first aid training should be provided for all staff in contact with prisoners as they are often first at the scene. Although I do not believe it would 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 clinical reviewer also makes reference to training in basic life support for non-clinical staff in his report.

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

CONCLUSION

113. The man was no stranger to prison custody and, following his recall back to Manchester, settled quickly into prison regime. He was nonetheless frustrated at being back in prison. His behaviour did not change significantly during his stay and certainly not to the extent that would allow staff to notice that he might harm himself.
114. Healthcare staff had significant contact with the man because of his ongoing back pain problem. He came into contact with nurses, physiotherapists and doctors. None noted or raised any concern that the man had any suicidal thoughts.
115. He did however raise concerns he was having about events from his childhood which were disturbing him. The extent of these concerns is not known, although it appeared that it took a lot of courage for him to raise the matter. In addition, the man was clearly having relationship problems which do seem to have come to a head in the hours before his death. The man was clearly upset at the thought of his relationship breakdown which is evidenced by the number of telephone calls he made to his girlfriend in addition to the content of what was said. His calls were not monitored and neither he nor his girlfriend reported any concerns to staff.
116. Having spoken to his girlfriend that afternoon, the man was alone in his cell and made the decision to take his life. Although he had raised other concerns whilst in custody, the catalyst for his mood change appears to be his relationship breakdown. He had never harmed himself before and I do not believe that prison staff could reasonably have realised that he might do so on this occasion.

RECOMMENDATIONS

1. The Director of Healthcare in conjunction with the GP service at HMP Manchester should ensure that previous medical records are obtained, especially when they have been alerted to a pre-existing medical condition when a prisoner is received into custody. This should also include checking other data sources where self harm risks have been identified.

The Prison Service has accepted this recommendation.

2. The Head of Healthcare should ensure the operational policy for the mental health in-reach team, refers to the circumstances in which information given by the patient should be cross-referenced with other sources, particularly where there is any mental disorder or treatment and doubt exists about accuracy, even if this means a delay in completing the assessment.

The Prison Service has accepted this recommendation.

3. The Head of Healthcare should use nationally or locally agreed guidelines or protocols to manage common conditions, including back pain, in line with practices in the community.

The Prison Service has partially accepted this recommendation.

4. 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.