# Investigation into the circumstances surrounding the death of a man at HMYOI Stoke Heath in April 2011

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

**March 2012**

The man was only 18 years old when he died in April 2011 at HMYOI Stoke Heath. He had transferred from HMP Woodhill to Stoke Heath six weeks earlier. He had become distressed for a time at Woodhill in January, but subsequently seemed to settle and was not subject to self harm monitoring at Stoke Heath. He was found hanging in his cell by an officer after lunch. Despite the efforts of prison officers, healthcare staff and paramedics, he could not be revived.

I would like to offer my sincere condolences to the man's relatives. To lose a relative in these circumstances at such a young age is particularly tragic. I hope that this report provides the family with a better understanding of what happened to him in prison.

The investigation was completed by two investigators. They interviewed staff and prisoners at Stoke Heath and Woodhill. One of my family liaison officers contacted the man's family to discuss their concerns. I am extremely grateful to the family for their contribution.

A clinical review of the treatment which the man received in prison was undertaken by a panel led by a clinical reviewer, who was appointed by the local PCT. It was assessed whether the care that he received in custody was comparable to that he could have expected in the community. It was found that staff responded 'promptly and professionally' to the emergency on 2 April.

I would like to thank the staff and prisoners at both Stoke Heath and Woodhill for their cooperation during the investigation.

It is hugely troubling when a young person dies in custody. The man had been a prisoner for a little under four months. He spent the first two months at HMP Woodhill, where he was often tearful and upset. Staff used self harm monitoring because they were concerned about the risk he presented to himself. After he transferred to Stoke Heath, he was noticeably calmer. He discussed his future plans and did not tell staff that he had any suicidal thoughts. His death in April came as a shock to all of the staff the investigators interviewed.

I make one recommendation and endorse two recommendations made by the clinical review panel as a result of the investigation which, together, should improve the assessment of vulnerable young people such as the man at Stoke Heath.

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.

**Nigel Newcomen CBE**
**Prisons and Probation Ombudsman** **March 2012**

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## SUMMARY

1. The man committed offences relating to the possession of weapons on 13 and 14 December 2010. He appeared in court on 15 December and was remanded into custody. He was taken to HMP Woodhill. He had not been to prison before. Although he told staff that he felt 'a bit shell-shocked', he said that he was not having any suicidal thoughts.

2. The man into a single cell on Houseblock 2A. Staff became concerned about him on 4 January when he told an officer that he had made a ligature and planned to hang himself. The officer confiscated the ligature and began Assessment, Care in Custody and Teamwork (ACCT) self harm monitoring. A nurse assessed him later that evening.

3. The next morning, the man attended his first ACCT review. Staff completed a thorough care plan outlining the issues that needed to be resolved to keep him safe. They arranged to check him intermittently during the day. A doctor assessed him and prescribed antidepressant and sleeping medication. Although he was initially tearful, his mood seemed to improve during the next few days.

4. Staff reviewed the man's ACCT monitoring for a second time on 11 January and closed the document with his agreement. However, they started self harm monitoring again two days later when he became very upset after receiving a photo of his partner's son in the post. He attended a further ACCT review meeting on 14 January. A doctor assessed him on 19 January. The same day, discipline staff reviewed self harm monitoring again and ended the ACCT process with his consent.

5. The following day, 20 January, the man became upset and damaged property in his cell. He went to an ACCT post-closure review meeting on 25 January and raised no further concerns. At the end of the month, he got into a fight and was briefly taken to the segregation unit, where a doctor assessed that he was safe and well. On 1 February, he received a 14 month prison sentence at the Crown Court. The next day, he began a further 28 day course of antidepressants.

6. The man transferred to HMYOI Stoke Heath on 15 February. He was checked by a healthcare assistant who recorded his recent difficulties at Woodhill but scored him zero on a mental health referral form. (This meant that he would be assessed within four weeks; had he scored higher, he would have been seen sooner.) A doctor assessed him the next day and, based on information he provided, decided to end his prescription for antidepressants. The doctor also asked two mental health nurses to review the mental health referral form. The next day, they made an 'urgent' referral, meaning that he would be assessed within two weeks.

7. A mental health nurse met the man on 22 February. Following the assessment, the nurse decided that he did not require any further treatment.

He was told how to ask for help from the mental health team if his mood worsened.

8. The man initially moved onto E wing (the induction unit) at Stoke Heath. On 8 March, he transferred to B wing. He seemed to get on well with the staff and spoke regularly to his personal officers. He applied to become a red band (trusted prisoner) and began working for the chaplaincy. He did not raise any further concerns with regard to his mental health. He did not tell any of the staff that he was feeling low or having any suicidal thoughts. He spoke to a couple of nurses and discussed his plans to join the army.

9. A member from the Shropshire Leaving Care Team visited the man on 16 March. On 31 March, he spent time working in the chaplaincy and asked the imam to sit with him and say a prayer. The following day, he showed the imam a photograph of his partner's child. He also went to an interview with a trainee social worker. He spoke to officers on B wing, who told my investigator that he had been laughing and joking with them.

10. The man was locked in his cell over the lunch period as usual. An officer unlocked his door at 1.44pm and found him hanging from the light fitting. He and a colleague supported his weight, cut through the ligature and lowered him to the ground. His colleague began cardiopulmonary resuscitation. Healthcare staff attended and two ambulances arrived at about 2.00pm. An air ambulance carrying a doctor landed just before 2.10pm. Despite the efforts of all the staff involved, he was declared dead at 2.22pm. The duty governor and chaplain travelled to the home of the next of kin to break the news of his death.

11. The man was 18 years old when he died. His behaviour at Woodhill contrasted markedly with his mood at Stoke Heath. He was openly tearful and distressed in the first month or two, whilst he gave no apparent hint of any negative thoughts to staff after he transferred. After he died, it was alleged by other prisoners that he might have been the subject of bullying. However, he never complained of being bullied at Stoke Heath. I explore these events in greater detail in the 'Issues' section of the report.

12. I make three recommendations as a result of the investigation. I have suggested some improvements to the mental health referral system used at Stoke Heath.

## THE INVESTIGATION PROCESS

13. The investigators were told about the man's death on 4 April 2011. Notices were issued to staff and prisoners at HMYOI Stoke Heath telling them about the investigation process and inviting them to contact my investigators.

14. One investigator liaised with a governor at Stoke Heath during the investigation. He visited Stoke Heath on 8 April with the other investigator to collect paperwork relating to the man's time in custody. They interviewed two prisoners, the governor who was on duty on 2 April and the imam.

15. One investigator contacted the local PCT to ask that a clinical review be carried out with regard to the medical treatment the man received in custody. The purpose of the review is to establish whether the care which he was offered in prison was comparable with that he could have expected in the community. A clinical reviewer led a clinical review panel.

16. The investigators and the clinical reviewer visited Stoke Heath on 1 and 2 June to interview nine members of staff. One investigator wrote to the Governor of Stoke Heath on 27 June outlining the initial findings of the investigation. He visited HMP Woodhill (where the man was held earlier in his sentence) on 15 June and 25 July to interview five staff. He gave verbal feedback to one of the governors about the investigation.

17. The investigator wrote to the local Coroner's office at the start of my investigation to inform them of its nature and scope. HM Coroner will be provided with a copy of my report.

**The man's family**

18. One of the Ombudsman's family liaison officers telephoned the man's grandmother, as his listed next of kin, on 25 May. She explained the purpose of my investigation and asked her if she had any concerns about the care that he received.

19. The man's grandmother expressed concern that he continued to receive bills relating to housing benefit while he was held in prison. She questioned the potential impact of letters about debt on someone who may already be feeling low.

20. When she spoke to the family liaison officer, she mentioned confusion over visiting orders (VOs). She explained that the man had sent VOs to both his mother and some friends. His mother telephoned the prison on the Tuesday prior to his death to arrange for her and two other family members to visit the following Sunday. She was apparently told that this wasn't possible as his friends had already booked a visit for Sunday under the same VO number.

21. She asked whether her grandson was told in advance that it was not his mother but two of his friends who would be visiting. He took his own life the

day before the visit and the family are concerned that anxiety about the visit could have been a potential trigger for his actions.

22. She mentioned that he had become very good friends with another prisoner and they had discussed getting a flat together on his release. She said that she had since learnt that his friend had been released on 1 April. My investigator has not determined which prisoner this might have been.

23. Finally, she expressed her opinion that her grandson hated being on his own. She was concerned he was in a cell by himself when he died. She was apparently told that this was because he did not get on with his previous cell mate and had asked to move cells. She questioned the process for moving prisoners to single cells given the opportunity this can present for vulnerable prisoners to take their own lives. As I go on to discuss, he was held on B wing, which consists almost entirely of single cells.

24. The family were provided with a copy of my draft report. I hope that the investigation has given them a better understanding of the circumstances surrounding his death.

25. When they responded to the findings in the draft report, the family wanted to know more about a visit that he received from his personal advisor from the Shropshire Leaving Care Team. On 8 March 2012, the investigator spoke to her on the telephone to find out more about her contact with him. In the 'Key events' section of the final version of the report, we have included a full account of her meeting with him.

26. We have included a summary of the family's response to the draft report on pages 40 to 42. We hope that this summary accurately reflects their thoughts about the investigation.

## HMYOI STOKE HEATH

27. Stoke Heath is located near Market Drayton in Shropshire. Until recently, the prison held juveniles (15 to 17 years old) and young adults (aged 18 to 21 years) in separate accommodation. However, the prison has recently changed its function and is no longer a 'split site'. The juvenile population have all transferred to other YOIs and the young adults will be joined by an adult population.

28. The man was an 18 year old young adult. He was initially held on E wing (an induction unit with shared cells) before transferring to B wing (the healthy living unit, which has 68 single cells and four double cells).

### Her Majesty's Inspectorate of Prisons

29. HM Chief Inspector of Prisons most recently completed an inspection of the young adult units at Stoke Heath in April 2010. The then Chief Inspector made the following comments:

> 'This inspection was solely of the provision for young adults. This is an age group about which the Inspectorate has repeatedly expressed concern: that the focus and the resources available are inadequate to meet their needs and risks. This report amply demonstrates that concern. In many key areas, we found that young adults' access to important activities and opportunities was severely limited.
>
> 'A high proportion of young adults had felt unsafe at Stoke Heath. Though considerable management attention had been given to violence reduction, the strategies and processes were overcomplicated and underused by residential staff.
>
> 'Bad language often went unchallenged, and shouting out of windows was endemic. Safer custody arrangements also needed greater clarity and focus, and the quality of ACCT documents was inconsistent and sometimes poor.
>
> 'There had been some remedial work to challenge shouting out of windows. Posters and notices to prisoners had been circulated and night patrols had been requested to challenge the behaviour consistently. However, we observed many occasions when this behaviour went unnoticed and/or unchallenged, and we were concerned about the opportunities this presented for bullying and antisocial behaviour.
>
> '…split sites like Stoke Heath also show very clearly the relative neglect of this risky and vulnerable group throughout the prison system, compared to the resources and specialist focus on under-18s – since the previous government's promise to replicate this for 18-21 year olds was never fulfilled. Split sites are gradually being abolished –

> but that may serve only to disguise the differential treatment that young adults experience, as well as its inevitable consequences.'
>
> 'Visits could only be booked by telephone but visitors reported no difficulties in accessing the service. The visitors' centre was clean and reasonably welcoming, and visits sessions normally started on time.'

**Independent Monitoring Board**

30. The most recent annual report published by the Independent Monitoring Board (IMB) at Stoke Heath covers the year from May 2009 to April 2010. (The IMB at each prison is made up of members of the public who are both independent and unpaid. They monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained.) The IMB wrote:

> 'We are concerned, as previously about the long distance from home of many of the trainees in this prison which has an immediate effect on the attitudes to staff and increases the likelihood of disruptive behaviour, often violent. Many families cannot visit because of cost and distance and it is not unusual for us to be told by trainees that they have not had a visit for weeks or even months.
>
> 'There has been frequent cancellation of education classes (see learning and skills) because of staff shortages and sickness. The classes for Young People are relatively protected because the staff cover them and so the Young Adults suffer. We understand this is because of financial constraints resulting from the contract with the provider.
>
> 'Inevitable financial cut backs mean that resulting staff shortages have an effect on regime including the undesirable length of cell lock up time and gym time as examples.
>
> 'We do believe however that although the prison is dealing with a volatile section of the community Stoke Heath is a safe establishment and frequent trainee questionnaires show that in the main they feel safe.'

**Previous deaths at Stoke Heath**

31. Apart from the man, there has been one other recent death at Stoke Heath. Another 18 year old man was found hanging in his cell in December 2010. The man had previously made a very serious attempt to take his own life and was an identified risk to himself. Like the man, he was scored zero when a member of staff completed a preliminary referral for mental health assessment during the reception process. Although a score of zero seems to indicate no concerns, there was evidence that both men had experienced recent problems. I go on to discuss this referral system in the 'Issues' section of my report.

32. Prior to 2010, the last person to take his own life at Stoke Heath was an 18 year old young adult in early 2005. The man had said that he was being bullied and the investigators were satisfied that staff had taken appropriate steps to help him, moving him to another wing for his own safety. As I go on to discuss, after the man died, there was some speculation that he might have been bullied at Stoke Heath. However, this was not an issue that he ever raised with staff.

33. A sixteen year old juvenile offender died at Stoke Heath in March 2002. At the time, the incident focussed attention on the safety of prisoners. The boy was found hanging in his cell.

**HMP Woodhill**

34. Woodhill is a high security prison located on the outskirts of Milton Keynes. It holds a maximum of just over 800 prisoners. As well as those prisoners who represent a high risk to the public, the prison also holds a large number of other men who have been remanded into custody at the nearby courts. The man was originally taken to Woodhill because he committed his offences in the local area. He was then transferred to Stoke Heath because this was a more appropriate location for a young adult.

35. The man stayed on House Unit 2A whilst he was held at Woodhill. At the time, the unit was solely dedicated to young adults aged between 18 and 21 years.

**Assessment, Care in Custody and Teamwork (ACCT)**

36. Assessment, Care in Custody and Teamwork (ACCT) self harm monitoring is started if a prisoner is thought to be at risk of harming himself. The prisoner is interviewed and a plan for his care is drawn up in response to his needs and concerns. The process is ongoing and the document remains open whilst the risk remains. ACCT reviews should be held at intervals commensurate with the risk that the prisoner presents to himself. Any staff who have contact with a prisoner can make entries in the document. The frequency of observations by staff is set out on the front cover, for example, 'hourly'. Staff must check the prisoner at least this often, they should conduct their observations at random intervals and write down all the checks in the ongoing record. Some of the scheduled checks must be 'quality observations', meaning that the member of staff speaks to the prisoner at some length and has meaningful interaction with him in order to gauge his mood and the risk he may present to himself.

## KEY EVENTS

37. The man was in local authority care between the ages of seven and sixteen years. He was still being supported by the Shropshire Leaving Care Team when he entered custody in December 2010.

### HMP Woodhill

38. The man had seven previous convictions but had never been to prison before. He was living in Milton Keynes when he committed an offence of possessing an offensive weapon on 13 December. The following day, he committed a further offence of having a bladed article in a public place.

39. On 15 December, the man appeared in court in relation to both offences. He was remanded into custody and taken to HMP Woodhill. During the reception process, a nurse assessed him. He reported some previous substance misuse. He said that he had no mental health problems and was not thinking about harming himself. A doctor also assessed him and prescribed an inhaler for his asthma.

40. An officer interviewed the man on his first night in prison. He told her that he had not been to prison before and felt 'a bit shell-shocked'. She explained what would happen to him during the first few days and answered his questions. He reiterated that he was not having any suicidal thoughts. The same evening, he telephoned his brother and spoke to an orderly to put his mind at rest. (Orderlies are trusted and experienced prisoners who new arrivals can talk to in order to learn more about prison life.)

41. Staff completed a cell sharing risk assessment (CSRA). The man was judged to present a low risk of harm to a potential cellmate. Again, no risk of self harm or suicidal intent was identified.

42. A healthcare assistant (HCA) completed a secondary health screening for the man on 16 December. She offered advice about managing his asthma and using his inhaler. An officer interviewed him on his second day in prison. The officer did not think that he seemed frightened. He continued his induction programme and met a member of the chaplaincy.

43. The man moved onto House Unit 2A (which held only young adults aged 18 to 21 years at the time). An officer told my investigator that he was tearful when he first arrived. He moved into a single cell. An officer was allocated as his personal officer and arranged for him to start work as a cleaner. (Prisoners can approach their personal officer in the first instance if they have any questions or concerns.)

44. On 31 December, the man made a court appearance via videolink and was convicted of his offences.

45. After lunch on 4 January, the man approached his personal officer and told him that he had put a ligature around his neck whilst he was locked in his cell

over the lunch period. He said that he had tried to hang himself but had stopped when he thought about his partner's newborn child (who he regarded as his son). He said that he missed his son. There were red marks on his neck demonstrating where he had tied the ligature. One of the officer's colleagues removed the ligature from the cell. (The ligature was made from a bed sheet and was tied to the window. The officer cut through the ligature to remove it.)

46. The personal officer stayed with the man to begin with because of the risk he might present to himself. He spent about 40 minutes talking to him, who was tearful. Because of what he had told him, the officer began Assessment, Care in Custody and Teamwork (ACCT) self harm monitoring.

47. When the officer opened the ACCT document, he recorded that the man was in a low mood and had said that he could not cope with prison life. He moved him from his single cell into a shared cell with another young adult (who he knew he got on with and was of a similar age). Senior Officer (SO) A told the investigator that he had been very upset because it was his first time in prison and he was missing his son.

48. The personal officer took the man into a side room and began an ACCT assessment interview at 2.30pm. He said that he had not had any suicidal thoughts before, but currently felt depressed. He was very tearful and said that he missed his family. He explained that he currently had no plans to deliberately take his own life. They discussed how he could spend more time out of his cell.

49. A nurse assessed the man at 8.35pm that evening. He still had visible marks on his neck. He said that he was depressed and asked for medication. The nurse referred him for a mental health assessment. He was checked at least once an hour by staff overnight until his first ACCT case review.

50. Staff completed the first ACCT review at 9.20am the following morning, 5 January. The man struggled to make eye contact and was reluctant to engage with the officers. They planned to invite a member of the mental health in-reach team to the next ACCT review. The officers encouraged him to begin attending education classes. He was also told to ask for a doctor's appointment to talk about possible antidepressant medication.

51. Staff were required to have a conversation with the man twice during the morning and twice during the afternoon and to check him five times overnight. The officers identified five issues on the ACCT care map which needed to be addressed: boredom, a lack of money, resettlement in the community upon release, depression and his upset because he missed his son.

52. A doctor assessed the man later that afternoon. He said that he was a loner and that the other prisoners were noisy and called him names. The doctor suggested a period of constant supervision to keep him safe, but he declined, saying that he was not thinking of deliberately harming himself.

53. The man agreed to share a cell and the doctor prescribed a 28 day ‘starting dose’ of 10mg of citalopram (an antidepressant). He was not allowed to keep this medication in possession in his cell but instead had to collect it each day from a nurse at the dispensary. The doctor also prescribed promethazine hydrochloride for the next four days to help him sleep. The doctor planned to review his progress two weeks later. He wrote in the clinical record that he should continue to be checked hourly by staff as part of the ACCT process.

54. The following day, 6 January, an officer spoke to the man. He was very tearful and said that the other prisoners had been making fun of him because of his attempt to take his own life. He asked to move to another unit. As a short term measure, the officer offered to move him to a different cell. However, when the officer checked him an hour later, he agreed to continue sharing the same double cell.

55. Over the next few days, the personal officer tried to keep the man busy by giving him cleaning jobs on the unit. He noticed that his mood began to improve. An officer told the investigator that he liked to be kept busy.

56. An officer checked the man again on the morning of 7 January. He said that he was feeling better. In the afternoon, he asked to move to a single cell. He said that he preferred single accommodation and that the move was not prompted by his cellmate. Another officer recalled during interview that the staff moved him into the cell nearest the unit office on the second landing in order to keep a close eye on him. During the next few days, his mood seemed to improve and he was seen laughing and joking on the wing.

57. SO A and the personal officer completed the second review of the man’s ACCT monitoring at 6.30pm on 11 January. (The officer had monitored his mood during the previous week because he oversaw cleaning duties on the unit.) The SO told the investigator that he seemed much happier and seemed to regret his use of a ligature a week earlier. He told her that he was feeling more positive and was not having any more suicidal thoughts. The officers recorded in the ACCT document that he had ‘come on in leaps and bounds’ during the last week. He had responded well to the ACCT process and was getting on well with the unit staff. He had visited the chapel and begun education classes. With his agreement, the officers decided to end ACCT monitoring.

58. The SO told the investigator that she felt confident to close the ACCT document because the staff on the unit were taking a close interest in the man’s welfare. He had not made any further attempts to harm himself or form a ligature since 4 January. She closed the ACCT document knowing that staff would carry out ‘post-closure’ checks for the next seven days.

59. At about 5.15pm on 13 January, Officer A delivered a letter to the man as he was having his dinner. A few minutes later, the officer checked him. He had his head in his hands. He was upset by the first photograph he had received of his son. He was tearful so the officer sat down to talk to him. They were

joined by another officer. He said that he felt guilty for not being present when his partner gave birth.

60. The man became so upset and tearful that he punched the wall of his cell. During his outburst, he said that he wanted to hold his child. Officer A took hold of his right arm for a few seconds and the other officer grabbed his left arm in order to stop him from injuring himself. After they let go, he calmed down. Officer A told him that he thought staff should recommence ACCT monitoring (which was currently in the week long post-closure phase) because he was so distressed. He initially resisted the idea because he thought that it was a sign of weakness, but he soon agreed to the plan.

61. The officer told my investigator that he wanted to put ACCT monitoring in place because the man was about to be locked in his cell for the night and he did not feel that staff had had enough time remaining to check his mood and ensure that his distress about the photo had passed. There was insufficient time to complete an ACCT review and he wanted to keep him safe overnight. He tried to remind him of the positive things that he had to look forward to, such as seeing his son in a few months. The officer stressed that the child was too young to have any memory of his time in prison.

62. The officer began a second period of ACCT monitoring at 6.00pm. He recorded in the ACCT document that staff were to check the man five times during the night and that he was to remain in his single cell because this was his preference. Because the original ACCT document had only been closed two days earlier and was still in the post-closure phase, staff did not carry out a new assessment interview and the care map remained the same.

63. The next day, 14 January, another SO and officer sat down with the man to complete another ACCT review. He said that he felt ‘fine’ but they all agreed to continue ACCT monitoring for a week to provide him with ongoing support.

64. The man spoke to an officer on 15 January. He seemed more settled and was getting on well with staff and prisoners alike.

65. A doctor assessed the man on 19 January. He read the previous doctor’s entry and wrote in the clinical record that his mood was stable. He added:

> ‘Medications effective… remains on an ACCT.’

66. The doctor also wrote in the ACCT ongoing record that the man’s mood was stable, that he was feeling alright and that he was thinking positively. He told the investigator that he planned to review his medication again four weeks later.

67. The man, SO A and the personal officer reviewed and ended the second period of ACCT monitoring later that day. The SO told the investigator that he seemed to be feeling more positive.

68. The next day, 20 January, the man became upset and damaged property in his cell, including a chair and the observation flap on the door. He was placed on report (meaning that he had broken one of the prison rules). Staff recorded in the ACCT post-closure document that he was tearful but had said that he was not feeling suicidal. Staff completed a security incident report (SIR) in which they suggested that his ACCT monitoring might have ended prematurely.

69. On 23 January, the man attended a hearing in front of a governor. He was placed on the basic Incentives and Earned Privileges (IEP) regime because of his poor attitude and the damage to property. (The IEP scheme is intended to encourage and reward good behaviour. Additional entitlements, such as more visits, can be gained in return for good behaviour. However, those entitlements can be lost if behaviour deteriorates.)

70. SO A completed an ACCT post-closure review with the man on 25 January. Staff had made daily entries about him during the last week. The ACCT document remained closed. The SO thought that he had trouble knowing how best to express his emotions. She felt that he might have an anger management problem.

71. The man failed to go to a doctor's appointment on 28 January. (The clinical review panel thinks that the appointment was probably made to review his antidepressant medication.)

72. The man got into a fight with another prisoner in the chapel on 30 January. The personal officer told the investigator that this fight was a petty argument over a compact disc. He said that the man did not find it easy to back down in a fight and the argument became overheated. He recalled that he could behave immaturely but that this behaviour was uncharacteristic. He was restrained by officers and taken to the segregation unit, where the doctor made sure that he was safe and well. He had grazed his forehead. He said that he was not thinking of harming himself. He said that the prisoner who he had fought with had been bullying him. There is no evidence that he reported further bullying to staff or asked for the matter to be taken further at Woodhill. Staff did not recommence ACCT monitoring.

73. Staff asked a member of chaplaincy to speak to the man the following day, 31 January. He apologised to the chaplain and told him that he needn't have troubled himself. The chaplain was impressed by his attitude.

74. The next day, 1 February, the man went to Crown Court and received a 14 month prison sentence. His release date was set at 15 July 2011. He was upset by the sentence and became tearful at court. He told the staff that he was being bullied. However, his personal officer remembered during interview that he had seemed relieved that the sentence was not longer when he returned from court.

75. The following day, the man was prescribed citalopram for a further 28 days. He was still not allowed to keep the medication in possession, so he collected

the antidepressant each day from a nurse. He did so on 3, 5, 6, 7, 10 and 11 February.

76. The man attended another hearing in front of a governor on 7 February following the fight in the chapel. (The records do not show the result of the hearing.)

**HMYOI Stoke Heath**

77. On 15 February, the man transferred to HMYOI Stoke Heath at his own request. (He had originally been told that he would move to HMYOI Rochester but he asked for Stoke Heath as it is closer to his family.) He moved into cell E2-26 on E wing (the induction unit.

78. A HCA assessed the man during the reception process. He told the HCA that he had tried to hang himself at Woodhill but that he was not currently thinking about harming himself. The HCA completed a Threshold Assessment Grid (TAG) mental health referral form. He recorded pertinent information about events at Woodhill but scored him zero.

79. The TAG form is a mental health assessment which looks at seven factors. These are intentional and unintentional self harm, risk from and to others, survival, psychological and social factors. There are five points on the risk scale from 'none' to 'very severe'. Scoring can range from zero to 24. The purpose of the assessment is to prioritise a patient's referral to mental health services.

80. A prison doctor assessed the man the next day, 16 February. They discussed his attempt to take his own life at Woodhill. The doctor issued a new inhaler. The doctor decided not to continue the citalopram prescription because the man said that he had recently stopped taking the medication and no longer wanted it. The doctor did not consult the handwritten prescription chart, which showed that he had still been collecting his medication a few days previously at Woodhill.

81. The doctor remembered during interview that the man was cooperative and conversational when they met. Because of his recent attempt to harm himself at Woodhill, the doctor sought the advice of two mental health nurses regarding the necessity for any further treatment. The nurses reviewed the TAG form the following day, 17 February, and made an 'urgent' referral for a mental health assessment, meaning that he should be assessed within two weeks. (The TAG score of zero would normally result in a four week referral.)

82. Another mental health nurse assessed the man on 22 February. He refused a full mental health assessment and said that he had no real concerns. However, the nurse gathered enough information to complete an assessment. The nurse scored him '3', meaning that he required no further input from the mental health team. He did not ask for any additional support. The nurse told him how he could access further help if he needed it. The nurse thought that he seemed happy with the outcome.

83. The man's personal advisor at the Shropshire Leaving Care Team wrote a letter to him on 23 February asking to visit him.

84. The man went to the asthma clinic on 2 March. On 4 March, he attended his education induction appointment. (Prior to this, he was unable to begin either education classes or employment.) On 8 March, he moved into a single cell (B1-01) on B wing. (B wing has 68 single cells and four shared cells.)

85. On 9 March, the man spoke to a teacher about learning support for his dyslexia and joining a reading scheme. She thought that he seemed keen, polite and engaged.

86. In the 'Issues' section of the report, I discuss allegations of bullying and suggestions that another young adult bullied him. Staff completed a Tackling Antisocial Behaviour (TAB) referral form about this prisoner's behaviour on 9 March. (Officers had previously made TAB referrals about him on 7 December 2010 and 3 January 2011.)

87. On 10 March, the prisoner moved into cell B1-02 on B wing, next door to the man. Although he had previously stayed on F and G wings, he could not return to either because he had assaulted a prisoner on the former and an officer on the latter. The same day, the man applied to become a Listener. (Listeners are prisoners who have been specially trained by the Samaritans to sit with and listen to other prisoners who are in distress. Their support is confidential and is not disclosed to staff or others.) The application was processed but no decision was made before he died.

88. The man also telephoned his personal advisor on 10 March. He was angry because he said that he had only been given her letter on 8 March. He also expressed frustration that his mother and grandmother had not received visiting orders. He said that he wanted her to visit.

89. The man spoke to his personal officer on 11 March. He expressed concern that family and friends were not receiving their visiting orders (VOs). The officer was able to confirm that one had just been issued to his grandmother. The officer also agreed to pursue his applications to become a Listener and transfer to HMYOI Thorn Cross. (He wanted to move to Thorn Cross because he thought that his partner and son would prefer to visit him there.)

90. On 14 March, the man applied to work as a 'red band' prisoner (red bands are trusted with significant jobs). The same day the decision was recorded that he would not be moving to Thorn Cross.

91. Two officers interviewed the man on B wing to complete an OASys assessment on 16 March. (OASys is an electronic risk assessment tool which helps staff to determine the risk of re-offending and the risk the offender presents to others.) One officer told my investigator that the man was polite and conversational. The officers recorded that there were no current concerns with regard to suicide and self harm on the basis of what he told

them. He talked about his depression and attempt to take his own life at Woodhill but said that he had had no suicidal thoughts since that time. He said that he had chosen not to take his antidepressant medication at Woodhill and had dealt with his feelings of depression by reading letters and telephoning his family.

92. The officers agreed on a number of objectives as a result of the man's OASys assessment:

- to complete the Thinking Skills Programme (TSP) (This is a group work programme which requires offenders to examine their behaviour and find alternatives to offending.)
- to complete an anger management course
- to gain enhanced prisoner status under the IEP scheme (he was currently on the standard IEP regime following his disruptive behaviour at Woodhill.)
- to become a Listener

93. The personal advisor visited him on the same day, 16 March. He looked well. He showed her his coursework. He was pleased with his recent educational achievements. He said that he had been going to the gym a lot. He told her that he had written to his former partner. He said that he had apologised to her in the letter for a 'nasty text' he had sent her. He was pleased that she had replied, and he showed the advisor letters from her.

94. The man told her that his mother and sister had visited him on 13 March. He said that he was expecting a visit from his brother on 20 March.

95. She told him that a supported lodgings in Shrewsbury where he had been living had been visited by a bailiff. He was in debt. She asked him who he owed money to. He explained that he had an outstanding mobile telephone bill. This amounted to approximately £200.

96. The advisor had been given two letters addressed to him about the debt by the owner of the supported lodgings. She was holding these letters at her office. She asked him for permission to open his correspondence. He gave her permission to do so.

97. The man told her that he had £500 of savings in an account. He gave her his bankcard and PIN number details and asked her to withdraw £100 and send him a postal order for a new pair of trainers. She suggested that he might use some of his savings to repay his debt. He said that he did not want to do this.

98. The man asked her if she would still be involved with his case after he was released from custody. She assured him that she would be. He also acknowledged that he had upset his partner in the past, and expressed hope that they might be able to resume their relationship at some stage.

99. He asked her to visit him again, and she said that she would. She returned to her office the same day, 16 March, and made a telephone call to his grandmother to confirm that she had been to see him.

100. On 17 March, the man spoke to an officer who was acting as his personal officer in the absence of the other officer. He said that he had no concerns and that he planned to move to Shrewsbury to be near his family when he was released.

101. On 21 March, a letter was sent to the man:

> 'I am writing to inform you that your referral to the Thinking Skills Programme (TSP) has not been able to progress to the next stage of the selection process.
>
> 'TSP is designed to target offenders who have specific treatment goals, which the programme addresses. You may not benefit from the programme at this time as your current level of need to address these treatment goals is lower than the recommended range set out by national guidelines.
>
> 'There may, however, be other courses at Stoke Heath that may be more beneficial to your particular needs. You may wish to discuss this further with your offender manager/supervisor. If your level of need changes, they may re-refer you for TSP in the future…
>
> 'You can contact the psychology department if you have any other questions about this decision.'

102. The man would have been released halfway through his sentence in July and his release was not dependent on completion of the programme.

103. The next day, he started work as a red band orderly in the chapel. The same day, a nurse treated him in the asthma clinic. He told her that he wanted to join the army. He ordered a new pair of trainers on 24 March. He spoke to his substitute personal officer again the next day, 23 March. The officer recorded that he had no issues and seemed settled. He helped him to 'resolve his money issues with the finance department'.

104. On 23 March, his personal advisor sent him his postal order to the value of £100.

105. On 25 March, he wrote back to her. He enclosed a sealed envelope containing a letter for his partner. He asked his advisor to pass the letter to her. She did so through his partner's social worker.

106. On 29 March, the man's mother visited the Leaving Care Team's offices and demanded her son's bankcard and PIN number. The personal advisor told her that she could not have these and that she would require his authorisation to hand them over.

107. The prisoner accused of bullying the man had moved to the healthcare wing for a couple of days on 27 March, but returned to cell B1-02 on 29 March.

Because of previous TAB referrals for threats, abusive behaviour and bullying, staff placed him on the second stage of the TAB process on 30 March. This meant that he was placed on the basic regime whilst staff kept him under observation and made daily written records of his behaviour. The TAB book accompanied him at all times so that staff could write in it wherever he was in the prison. He remained on B wing because the second stage of the TAB process does not require separation from other prisoners.

108. A nurse treated the man for his suspected asthma on 30 March. He again talked about his intention to join the army. He seemed to be planning for the future. The nurse was not convinced that he had asthma and agreed to provide him with a letter to this effect which he could give to the army.

109. On 31 March, the personal advisor wrote to the man informing him that his mother had come to the office asking for his bank account details. She indicated that she had refused to hand these over, but asked him what he wanted to do.

110. On the same day, 31 March, an officer made a TAB referral about the other prisoner's behaviour. Another prisoner in cell B1-03, said that this prisoner and two other prisoners had threatened to stab him if he left his cell. This prisoner was held in cell B1-02, next door to the man, who was in B1-01.

111. The man spoke to an officer on 31 March. He said that he had no issues and was just waiting to hear about the transfer to Thorn Cross that he had requested. Although this YOI was further away from his family, he thought that it would be a nicer environment for his partner and son to visit. (It is unclear from the records why this decision had still not been communicated to him.) The same day, he worked in the chapel as usual. He asked the Imam to say a prayer for him, although he did not explain why. They sat together for a little while.

112. The next day, 1 April, the man showed the Imam a photo of his son. He carried out his usual duties in the chapel. A trainee social worker interviewed him in the chaplaincy for about half an hour. She had been contacted by a community social worker who was arranging his Looked After Children (LAC) review on 31 May. (He had recently turned 18 and was leaving the care system.) She told the investigator that she was advised that he might try to tell her 'what she wanted to hear'.

113. She went to speak to him in order to inform him that his LAC review would be happening in the next couple of months and to ask him who he wanted to be there. He asked for his brother to attend the LAC review. She told my investigator that he was very open and forthcoming during their meeting. He was talkative and spoke very positively about the future. He seemed to be focussed on his plans after release from custody.

114. The man talked about a forthcoming visit from his mother and her partner. He spoke in a very caring way about his mother. She got the impression that he cared deeply for his family and was very protective of them. He did not

mention any problems with bullying or suicidal thoughts. He had a couple of minor concerns about some trainers he had bought and his cell tidiness rating. He said that he wanted to move to I wing.

115. The man said that he was not worried about finances because his social worker had his bank card and could send in money. He said that he had a good relationship with his partner. He talked about his plans for release: getting a part-time job, returning to college and getting a place of his own. He mentioned that he had still not been told the outcome of his application to transfer to Thorn Cross. He remarked that he had matured at Stoke Heath. She agreed to speak to him again the following week.

116. During interview, two officers both told my investigator that the man laughed, chatted and joked with staff for five or ten minutes during the day. Officer A remembered that he also talked to him about visits. He was very keen to know when his mother would be visiting him. The officer checked the P-NOMIS electronic records system and told him that he was due to be visited by two friends that Sunday afternoon. He seemed 'indifferent' to this news.

**2 April**

117. On the morning of 2 April, the man briefly spoke to Officer B about his forthcoming visits. He did not report any concern or confusion about who was visiting him the next day (confusion about VO numbers came to light after he died). He also spoke to a SO briefly about his canteen sheet. He collected his dinner as normal. Officer B locked him in his single cell on B wing (B1-01) at the usual time of about 12.15pm. (Prisoners are always locked up during the lunch period.) They did not speak.

118. The prisoner in the next cell told my investigator that they had a conversation through their respective cell windows before the man said that he was going to go to sleep. He said that he subsequently heard the sound of sheets ripping.

119. At 1.44pm, Officer C found the man hanging from the strip light fitting in his cell when he unlocked his door to collect his dirty dinner plate. His was the first cell the officer had unlocked. He had tied and affixed a ligature made from a torn bed sheet from both ends of the strip light.

120. The officer held him by the waist in order to support his weight. Unable to lift his radio to speak, to save time he initially pressed the personal alarm button on the top of his radio in order to alert staff in the control room to the emergency. The officer also called out to Officer B.

121. Officer B entered the cell and used his anti-ligature knife to cut through the ligature whilst Officer C continued to support the man. Together they lowered him to the cell floor. Officer B only managed to cut the ligature from the man's neck with some difficulty because it was tied so tightly.

122. He then checked if the man was breathing. He was not, so the officer began cardiopulmonary resuscitation (CPR). (The officer had first aid training.) Officer C contacted the control room on his radio to advise them that an emergency was in progress. He had to do this twice because his radio proved unreliable.

123. Control room staff telephoned the ambulance service at 1.45pm. They also notified other staff to assist on B wing. A SO later complained that the ambulance service asked for a lot of information which seemed unnecessary during the telephone call, including the man's date of birth, which he had to retrieve from the P-NOMIS system. Nonetheless, an ambulance was dispatched at 1.46pm.

124. Another SO arrived in the cell and helped Officer C give CPR. The former gave chest compressions whilst the latter gave breaths using a mask. A Senior Nurse (SN) came to the wing, bringing the emergency bag with him. He asked the officers to help him move the man out into the corridor to provide sufficient space to use a defibrillator. (A defibrillator is a machine that advises the user whether to administer an electric shock in order to restore the heart's natural rhythm.) The SN then gave chest compressions whilst Officer C continued to give breaths.

125. A Sister brought a defibrillator and oxygen to the cell. The SO gave chest compressions and the Sister began giving breaths. The Sister inserted an airway and attached a bag and mask whilst the SN prepared and attached the defibrillator. The defibrillator advised staff not to shock the man but to continue performing CPR. The Sister and SN did so and asked for other healthcare staff to attend.

126. Each time that staff attached the defibrillator, the machine advised them not to shock the man and to continue giving CPR because it could not detect a heart rhythm. Nursing staff came to help their colleagues; they gave breaths and chest compressions in rotation.

127. Two ambulances arrived in quick succession at 1.58pm and 2.03pm. Two paramedics made their way to the cell and took over CPR from the staff. At 2.09pm, a Shropshire air ambulance landed in a nearby field. (It was supposed to have landed on the football pitch inside Stoke Heath.) An officer from the care team escorted the air ambulance crew, which included a doctor, to the cell.

128. In spite of the efforts of staff, the doctor declared the man dead at 2.22pm. Staff found a note in his cell addressed to his mother and partner next to a photograph of his son.

129. Prison staff spoke to the other young adults on B wing to check their welfare, paying particular attention to the more vulnerable prisoners. Police Intelligence Officer (PIO) provided support, contacting the police and Coroner, obtaining permission for the man's body to be moved back into the cell and locating details about his next of kin.

130. At 3.00pm, the duty governor tried to telephone the man's grandmother (his named next of kin) but got no answer. (Although he was unsuccessful, his telephone call was contrary to Prison Service Order 2710, which requires prison staff to break the news to relatives in person if at all possible.) A few minutes later, staff began reviewing all prisoners who were subject to ACCT monitoring. All young adults were spoken to by a member of staff through the cell door.

131. The duty governor sent Officers B and C home for the rest of the day. He offered them a taxi and telephoned them later to check on their welfare. Other B wing staff were given the opportunity to work on a different wing for the rest of the day.

132. At about 3.30pm, an officer escorted the prisoner next door to the man from his cell to the healthcare centre. He was not coping well and was tearful and upset. He said that he had spoken to him over the lunchtime period and they had been laughing and joking. Later, he had apparently said that he felt depressed. The prisoner claimed that he told the man 'not to do anything stupid'. He said that he had offered him tobacco. He had apparently told him that he was going to go to sleep. The prisoner stated that he shouted to his neighbour and banged on the wall half an hour later but got no reply. He expressed regret that he had not pressed his cell bell to alert staff. The officer completed a Security Incident Report (SIR).

133. At 4.20pm, the duty governor set off to tell the man's grandmother about his death in person. He was accompanied by the Anglican chaplain. They called in at a police station. Police officers, travelling in a separate car, accompanied the prison staff to the address. She was out shopping at the time, so the police officers obtained her mobile telephone number for the governor. He telephoned her and asked her to return home immediately.

134. It was about 6.00pm when the man's grandmother arrived home. The duty governor and chaplain went into the house with her to tell her what had happened. The police officers remained outside to offer support. The grandmother asked the governor to accompany her when she went to tell his mother. He went outside to consult the police, who advised against this because the man had not named his mother as his next of kin. He reluctantly told the grandmother that he and the chaplain would be unable to travel with her to tell her daughter the news.

135. Whilst the duty governor was breaking the news to the man's next of kin, the Governor chaired a hot debrief meeting at 5.10pm. (This meeting allows managers to check how staff are coping and to learn any immediate or urgent lessons from the emergency.)

136. The following day, the man was remembered at the Sunday service in the prison chapel. Officers B and C returned to work on B wing. The man's mother, her partner and his grandmother visited the prison. His mother asked the duty governor about her son's offence, but he felt unable to discuss this

with her because she was not the named next of kin. Her partner asked if they could visit his cell, but the governor said that this was not possible for the time being because it was still sealed pending further investigation by the police and my investigator.

137. Staff completed a SIR on 4 April. Another prisoner told an officer that he had spoken to the man before lunch on 2 April. The man had apparently promised to give him some tobacco after lunch. The prisoner also said that he heard the prisoner next door to the man's cell talking to him through the window during lunchtime. He did not say what they were talking about but mentioned that, after 20 minutes, the man had said that he was going to sleep.

138. On 4 April, the man's mother returned to the Leaving Care Team's office and once again asked for his bankcard and PIN number. Because he had died, one of the personal advisor's colleagues gave these to her. The personal advisor was not in the office at the time.

139. In the absence of the Governor, the Deputy Governor wrote a letter of condolence to the man's grandmother on 5 April.

140. Staff completed a further TAB referral about the prisoner suspected of bullying on 6 April. He had verbally abused and threatened an officer. The same day, the Deputy Governor chaired an operational debrief meeting about the emergency. About 30 young adults from B wing went to a remembrance service in the chapel.

141. On 7 April, a HCA completed an SIR because he was suspicious after having a conversation with a prisoner. The prisoner had stressed how he and the prisoner next door to the man had looked after him and didn't like bullies. The HCA thought these remarks strange and out of character for the prisoner who was in the cell next door, who had a history of bullying allegations.

142. The next day, 8 April, an officer completed another SIR after one of the prisoners suggested to her that the man had confided in another prisoner that 2 April was the anniversary of the death of his child.

143. The prisoner suspected of bullying transferred to HMP Aylesbury on 13 April. He was still subject to TAB 2 procedures when he left Stoke Heath. The third stage of the TAB process had not been implemented. His TAB book accompanied him to his new prison.

144. Staff held a critical incident debrief meeting on 15 April. The man's funeral was held in Shrewsbury on 19 April.

## ISSUES

### The man's mood

#### Woodhill

145. The man's behaviour at Woodhill and Stoke Heath differed markedly. He experienced a period of crisis at Woodhill in January. SO A described him as 'vulnerable' and a 'poor coper' when he first arrived. His original personal officer recalled that he looked rather like 'a rabbit caught in the headlights'.

146. The SO said that the man was 'likeable and polite' and was able to express his emotions to staff when he felt upset. She recalled that the staff were fond of him and that he seemed to benefit from the attention that he received once ACCT monitoring began. He seemed to appreciate the officers taking an interest in him and responded well to the ACCT process.

147. During his early days at Woodhill, the man was often tearful and his mood would change rapidly. The SO and personal officer both remembered that, because he 'wore his heart on his sleeve' it was easy for the staff to monitor his mood and use ACCT monitoring appropriately. He didn't hide his feelings and felt able to approach and speak to the staff. He seemed able to signal his distress.

148. The man's personal officer at Woodhill told the investigator that the man's mood frequently varied during those first few weeks. He could be happy (often playing mischievous pranks), aggressive and upset or sometimes sad and quiet (avoiding eye contact). The officer recalled that he did not like prison at all and found it 'tough' to begin with. However, he remembered that the man got on well with other prisoners and was well liked by the staff.

149. SO A told the investigator that she considered him to have been something of a 'success story' when he left Woodhill. She recalled how he had arrived as a vulnerable young adult in a low mood and when he transferred seemed to be coping and to have adjusted somewhat to prison life. The original personal officer agreed that he soon settled into the unit, found his feet and gained in confidence. Although he damaged property in frustration, he never behaved aggressively towards officers.

#### Stoke Heath

150. The man's behaviour noticeably improved at Stoke Heath. He progressed quickly and became a trusted redband orderly, working in the chapel. In contrast to his behaviour at Woodhill, he never seems to have expressed any negative emotions to staff or disclosed that he was thinking of harming himself.

151. All of the staff my investigator spoke to at Stoke Heath remembered the man as chatty, polite, friendly and liking a joke. There is no evidence that he ever

behaved in the agitated or upset manner that he had done at Woodhill. He appeared to be making plans for the future.

**Assessment, Care in Custody and Teamwork (ACCT) self harm monitoring**

152. The two ACCT documents opened and closed at Woodhill in January contained examples of good practice. The care map was thorough and identified the man's needs. There was good continuity at ACCT reviews, with the same officers meeting him and monitoring his progress. The same two members of staff (SO A and his personal officer) ended both periods of ACCT monitoring on 11 and 19 January.

153. I have some reservations about the relatively rapid closure of both periods of ACCT monitoring. When the man's family responded to the findings in the draft report, they shared these reservations. They think that both ACCT documents were closed prematurely at Woodhill.

154. I do not doubt that staff monitored the man's mood and were satisfied on both occasions that it had improved. They appeared to form a good rapport with him and offer appropriate support. However, given that the second period of ACCT monitoring was deemed necessary so soon after the first ACCT document was closed within seven days, it might have been wise to apply caution and continue monitoring at a reduced frequency for another week. Nonetheless, on balance I judge that the decisions staff made were reasonable at the time and I note that he was kept safe and well during this crisis period.

155. Following the closure of the second document, there were two incidents which could have prompted further periods of ACCT monitoring. On 20 January, the man became upset and damaged property in his cell. However, this incident occurred within the seven day ACCT post-closure period, during which staff were still keeping an eye on him and making daily entries. The SO was satisfied when she completed her post-closure review on 25 January that a further period of ACCT monitoring was not required.

156. The man became involved in a fight on 30 January and was taken to the Separation and Reintegration Unit. ACCT monitoring was not started. He did not report any suicidal thoughts and was assessed by a doctor. He was also checked by a member of the chaplaincy the next day, who was pleased with his attitude. I am satisfied that staff took appropriate steps at the time to keep him safe.

**Mental health treatment**

**Threshold Assessment Grid (TAG) referral form**

157. As we know, the man was subject to two periods of ACCT self harm monitoring at Woodhill. When he arrived at Stoke Heath, he was assessed by a HCA, who completed a TAG referral form. He told him that he had previously tried to hang himself. The purpose of the referral form is to

prioritise the mental health treatment that a prisoner receives. It is an obligatory part of the mental health assessment process at Stoke Heath. The form asks a lot of questions in language that might not be considered plain English. (Any member of staff, not only healthcare, is supposed to be able to use the form.)

158. The HCA scored him zero, which seems contradictory given the problems that he experienced the month before (and which the HCA recorded on the referral form). A score of zero normally results in an assessment within four weeks.

159. The clinical review panel has expressed concern that another young adult who took his own life at Stoke Heath in December 2010 was also scored zero when he arrived. He was a young man whose problems were even more clearly demonstrable than the man's. His previous behaviour should have raised some concerns about his mental health on the TAG referral form. I have recently published the report of that investigation and made the following recommendation:

> 'The Head of Healthcare should ensure healthcare staff attend training events aimed at achieving more consistency with the TAG assessment process.'

160. The HCA told my investigator that he had a long conversation with the man before he completed the TAG referral. He remembered that he gave the impression that he had not made a serious attempt to take his own life. The HCA thought that he seemed 'friendly and upbeat'.

161. The HCA referred the man to the doctor, who in turn consulted two mental health nurses. They effectively overruled the original decision and referred him for an urgent assessment with a mental health nurse within two weeks (and he was assessed by a mental health nurse about a week later). Neither the doctor nor the nurse raised any concerns about him and neither believed that he required any further input with regard to his mental health.

162. The clinical review panel noted that the mental health nurses recommended an urgent referral within two weeks on the basis of the HCA's written comments, rather than his score. The panel did not believe that the TAG score of zero affected the man's mental health treatment. Indeed, they wrote that the concerns identified on the TAG referral form were 'addressed promptly and ahead of the priority indicated by the TAG score'. Nonetheless, it is worrying that two young men with histories of difficult and concerning behaviour could be assessed with such a low score on the TAG form. The panel believes that the process needs to be reviewed and simplified. I endorse their additional recommendations:

**The Head of Healthcare should discuss through regional forums the problems that have occurred with the Threshold Assessment Grid referral system, with a view to simplifying the initial reporting form.**

**The Head of Healthcare should remind staff of the need to take into account previous self harm when completing the Threshold Assessment Grid initial assessment.**

**Antidepressant medication**

163. The man was prescribed a low dose of citalopram from early January after he tried to hang himself at Woodhill. The doctors who initiated and reviewed the prescription both told my investigator that they intended for him to continue taking the antidepressant medication for six months in order to accurately gauge whether the drug was having a positive effect on his mood.

164. The prescription for citalopram was ongoing when the man transferred to Stoke Heath. The prescription chart shows that he had still been collecting his antidepressant medication at Woodhill (albeit not every day). After he transferred, another doctor stopped the prescription immediately. During interview, the doctor told the investigator that he had accepted the claim that he had stopped taking the drug. The doctor did not check this information by consulting the prescription chart. The chart was available to my investigator as part of the clinical record that he collected from Stoke Heath after the death, so it is reasonable to conclude that it arrived with him from Woodhill and was available to staff.

165. Although the doctor stopped the medication, he took the precaution of consulting the mental health nurses, who referred him for a mental health assessment with a mental health nurse. In the event, the nurse did not identify any concerns and no further antidepressants were prescribed. The doctor told the investigator that he would have considered continuing the citalopram prescription if he had checked the drug chart and realised that he had been taking the medication recently at Woodhill. I make the following recommendation:

**The Head of Healthcare should remind staff to consult the prisoner's clinical record fully during the reception process.**

**Bullying**

**Woodhill**

166. The man's family responded to the findings in the draft report. They expressed concern about the events of 6 January, when he told an officer that he was being made fun of because of his recent suicide attempt. Staff offered to move him, but ultimately he decided to stay where he was. He does not appear to have identified any individual prisoners. The family thought that the incident was 'extremely significant'.

167. SO A told the investigator that the man did not mention any problems with bullying when she reviewed his ACCT monitoring on 11, 19 and 25 January. He fought with a cellmate at the end of January who he claimed had been

bullying him. There is no further reference to any bullying in the next two weeks in any of the records before he left Woodhill.

**Stoke Heath**

168. The man never complained about bullying to staff at Stoke Heath. However, he and another prisoner moved into neighbouring cells on B wing in early March (B1-01 and B1-02). Staff told my investigator that this prisoner was a difficult prisoner to manage. His cell movement records show that he was frequently moved between the Separation and Reintegration Unit, the healthcare unit and different residential wings. Staff had completed a number of TAB anti-bullying referrals about him and he was subject to TAB stage 2 monitoring. (This meant that he was placed on the basic regime whilst staff kept him under observation and made daily written records of his behaviour. The TAB book accompanied him at all times so that staff could write in it wherever he was in the prison. He remained on B wing because the second stage of the TAB process does not require separation from other prisoners.) Two days before the man died, the prisoner was suspected of threatening another prisoner in cell B1-03.

169. When the investigator opened the investigation, staff told him about a Security Incident Report which indicated that this prisoner might have shouted out of his cell window to the man in the neighbouring cell during lunchtime on 2 April. The prisoner was being monitored by the anti-bullying team at the time but not in relation to the man. The investigators interviewed this prisoner. He denied bullying the man and there is no other evidence to substantiate the suggestion. The former Chief Inspector of Prisons made the following comments when she inspected the young adult units in 2010:

> ‘A high proportion of young adults had felt unsafe at Stoke Heath. Though considerable management attention had been given to violence reduction, the strategies and processes were overcomplicated and underused by residential staff.
>
> ‘Bad language often went unchallenged, and shouting out of windows was endemic...’

170. After my investigator interviewed staff at Stoke Heath, he provided the Governor with feedback about the issues the investigation had identified. The Governor wrote back to the investigator and gave the following response about the issue of bullying:

> ‘Our investigations into the period that lead up to the man’s death have produced no evidence to suggest that he was the victim of bullying by the prisoner or indeed any other individual. We have a robust Anti-Social Behaviour Reporting System in place and no forms regarding him were submitted in his time at Stoke Heath.
>
> ‘There had been two forms submitted that indicated that another prisoner may have been a victim of bullying: the first of which named

no suspected perpetrators and the second named the prisoner suspected of bullying, along with two other young adults.

‘This prisoner’s behaviour whilst at Stoke Heath did prove challenging and staff were well aware of the need to manage his behaviour effectively and reduce any negative impact it may have on others. The possibility of transferring him to another establishment in order to remove any threat he posed to the stability of others was explored, however he was subject to a medical hold that was not removed until 1 April 2011. Following the removal of this restriction, I can confirm that he was transferred out of Stoke Heath as a discipline transfer.’

[Medical hold is a means of keeping a prisoner at a particular establishment if they need to attend scheduled procedures at outside hospital and a transfer would disrupt their ongoing treatment.]

171. Because this prisoner has denied bullying the man and the man himself never mentioned any bullying to staff, it is very difficult to know the truth of the matter. If any bullying of him did occur, it is also impossible to know whether it took place over a period of time or only on 2 April.

172. In the draft report, I urged the Governor to think again about the concerns the former Chief Inspector of Prisons raised in her report. In particular, we drew attention to two of the recommendations she made (and include the latest response from the management team at Stoke Heath):

- There should be further work to understand why a significant proportion of young adults feel unsafe.

  Response from Stoke Heath:

  ‘Information surrounding prisoners’ perception of safety, alongside other significant issues, will be gathered through the trainee consultation meetings, focus groups and the revised exit survey. Action will be taken to address emerging concerns in whatever manner is considered appropriate.

  ‘In consideration of our re-role process and the needs of our new prisoner population the Interventions Services have been commissioned to complete some investigative work into prisoners’ perception of safety at Stoke Heath. The Young Adult element of this has already been reported on (August 2011) and actions identified and agreed from the conclusions drawn. The same process will be undertaken with the Adult population as it substantiates and any arising issues will be addressed. Prisoner perceptions of safety is a priority for the establishment and will therefore be kept under continual review.‘

- Staff should challenge abuse from windows and bad language robustly and consistently.

Response from Stoke Heath:

'All staff will be made aware of the zero tolerance policy on this issue through the induction process. There will be periodic notices to staff on how this should be challenged and what should be done if it occurs. The communication with prisoners will be improved and details surrounding possible sanctions and consequences will be displayed. The perpetrators will also be addressed under the TAB system. Last notice issued 28/07/2011.'

173. When they responded to the draft report, the man's family correctly identified that the Ombudsman had previously made recommendations about 'shouting out' from cell windows during an investigation of a death in custody at HMYOI Lancaster Farms. The family thought that the draft report should have recommended that steps were taken across the YOI estate to reduce opportunities for bullying. Whilst we do not make a recommendation in this instance, because there is insufficient evidence to do so, we draw the family's comments to the Governor's attention and are pleased that he has adopted a 'zero tolerance' approach.

**Finances**

174. The man's family expressed concern that he might have had financial worries and received bills whilst he was in custody which caused him anxiety. I am reassured that the housing officer at Woodhill wrote to the housing benefit department at Milton Keynes Council on 21 December asking them to close his housing benefit claim because he would not be returning to his address.

175. My investigator has not found any evidence to indicate that the man was unduly troubled by his financial situation. However, he did talk to an officer at Stoke Heath on 23 March, who recorded that he had helped him to 'resolve his money issues with the finance department'. I am satisfied that the officer took steps to help him. The discharge balance report prepared by staff after he died shows that he had £115.92 private cash.

**Single cell**

176. The man's family have expressed concern that he was held in a single cell when he died. Of the 72 cells on B wing, 68 are single occupancy. There was no evidence available to staff that he was at imminent risk of harming himself and he had repeatedly expressed a preference for single cell accommodation at both Woodhill and Stoke Heath. I consider that it was reasonable of staff to keep him in his single cell.

177. After the family received the draft report, they responded as follows:

> 'The family remain concerned that he was located in a single cell. In their view, there would have been a reduced risk of him taking his own life if he was located in a double cell.'

### Meetings with social services staff

178. The man's family had asked the investigator about meetings that he had had with social services staff. They were worried that a social worker had advised him against pursuing a relationship with his former partner.

179. In the draft report, the investigator described the man's meeting with the trainee social worker on 1 April. During interview, she confirmed that she had no knowledge of the relationship and had not therefore spoken to him about it. Similarly, his family thought that she might have passed items of mail onto him during their meeting. She told the investigator that she did not pass any letters on.

180. She said that news of his death came as a shock to her because he had spoken so positively about the future at their meeting the day before. She told the investigator that he had not given any hint that he might try to harm himself.

181. When the family responded to the draft report, they asked the investigator to provide more information about another meeting the man had attended. The investigator interviewed the personal advisor about a meeting which she had had with him at Stoke Heath on 16 March. The investigator has added details of her contact with him to the 'Key events' section of the final report. We hope that the additional information provides a fuller account of what happened to him.

### Response to the emergency

182. It appears that the man made deliberate plans to hang himself. He died during the lunch period. He would have known that he was unlikely to be disturbed for over an hour. He fashioned quite a complex ligature that hung from both sides of the light fitting. Although it was subsequently suggested that the date of 2 April held particular significance for him, it is impossible to know precisely what he was thinking. He did however leave a note that detailed specific instructions about his funeral and other matters.

183. The clinical review panel considered that, after the man was found hanging in his cell, the emergency was dealt with 'promptly and professionally by all staff involved'. I would like to commend Officer B for beginning CPR as soon as he and Officer C found him. He had current first aid training. All too often I find that discipline staff have little, no or outdated training and lack the confidence to begin CPR. Although he could not be revived, I consider that the staff responded to the emergency in a swift and organised manner.

184. A SO complained that the ambulance service asked for a lot of information on the telephone which seemed unnecessary, including the man's date of birth, which he had to retrieve from the P-NOMIS electronic record system. The duty governor thought that the SO struggled to convince the emergency services of the seriousness of the incident. I do not make a recommendation, but I would encourage the Head of Healthcare to liaise with the local

ambulance service to devise an agreed protocol for emergency calls. A recent investigation at HMP Kingston has demonstrated this to be good practice.

185. Officers B and C both expressed concern about their radios. They thought that these were old and unreliable pieces of equipment. Officer C had to radio the control room twice to tell them that an emergency was underway. Although the alarm was raised without delay in this instance, this is clearly a matter of concern. After the investigator provided the Governor with preliminary feedback about the issues that the investigation had identified, he wrote back as follows:

> 'I acknowledge the need for the radio system to be fit for purpose and have asked that the Head of Operations review and, where considered necessary, replace the radio system and its components in order to address this identified area of risk.'

**Visiting orders**

186. The man's brother, his mother and her partner understood that they were due to visit him on the afternoon of Sunday 3 April. However, he had also completed a handwritten application asking for his friends to visit and the P-NOMIS system had scheduled their visit for the same afternoon using the visiting order number allocated to his family members.

187. The manager responsible for the visits department told my investigator that staff have been unable to fully explain the confusion about the visiting orders. It would seem that an error on the P-NOMIS system mixed up the visits of the man's family and his friends. Since he died, she said that her department has not experienced any further similar problems, to the best of her knowledge.

188. After my investigator wrote to the Governor with preliminary feedback, he replied with the following response:

> 'We have received confirmation from the NOMIS Live Service Application Support Team that there were errors on the P-NOMIS system on the weekend of the man's death, however it cannot be stated categorically that these were the cause of this particular error. This issue is still the subject of internal investigation with a member of staff due to be interviewed by the investigating officer following her return from annual leave on 14 August 2011. Once a final conclusion has been reached on this matter I will update you accordingly.'

189. Following publication of the draft report, the management team at Stoke Heath provided the following update:

> 'The internal investigation and supporting documentation from NOMIS demonstrated that the error associated with the man's visiting order was purely human and the member of staff has been advised of this.

> ‘Visits Booking Services have now moved to a regional structure and are no longer under Stoke Heath’s control. It was therefore decided that no further action is necessary.’

190. The man’s family have expressed concern that he would have been anxious when he found out that the two young men were visiting him on the afternoon of Sunday 3 April. However, my investigator has seen the handwritten document which shows that he personally requested the visit, writing the word ‘mate’ in the relationship column. One officer also did not think that he seemed especially anxious when he confirmed the visit on 1 April.

**Telephone calls**

191. The man made regular telephone calls at Stoke Heath using a unique PIN number from his arrival in mid-February until 10 March. However, there is no record of any telephone calls in the last three weeks of his life, which seems rather strange given that he seemed to be in frequent contact with family members for the first part of his stay. My investigator has confirmed that he did not use another prisoner’s PIN number to telephone his family. He tried to make calls on 12 and 15 March but after this made no further attempts. There was no remaining credit on his account. It is of course possible that he used an illegal mobile telephone to call family and friends, but there is no evidence of this.

**Induction unit / Purposeful activity**

192. At the end of February, the man told his family during telephone calls that he was locked up for 23 hours a day at Stoke Heath. He was held on E wing (the induction unit) between 15 February and 8 March. My investigator spoke to a SO, who confirmed that on weekdays he would have been given 50 minutes association in the early evening and an exercise period during the day. During the weekend, he would have been offered an hour’s association. Other than these opportunities, he would have spent most of his time in his cell.

193. The man completed a number of induction sessions during his first few days at Stoke Heath, but was then left with little to occupy his time until 4 March, when he went to his education induction appointment. Until prisoners are offered this session, they cannot apply for education classes or employment.

194. It seems understandable that, for a couple of weeks at the end of February, the man felt like he was always locked in his cell. Staff on E wing explained that there was an influx of young adults during this period, meaning that education sessions were too full and progression to other wings stalled.

195. The former Chief Inspector of Prisons made the following observations when she inspected the young adult units in 2010:

> 'Many young adults spent lengthy periods locked in their cells with little to occupy them. We found over a third of young adults locked up during the core day. Exercise was not offered daily…
>
> 'The published core day provided a best-case scenario for a full-time employed prisoner of 7.75 hours, and the worst case, for an unemployed prisoner, was two hours out of cell. We spoke with one young adult on basic regime who had only spent less than one hour out of cell on two consecutive days. A snapshot roll check during the inspection showed that 36% of prisoners were locked in their cells during the core working day.'

196. The Governor provided the following comments after receiving preliminary feedback from the investigator about the investigation:

> 'It is unusual for a young adult to be on the induction unit for a period longer than a week in the absence of any specific requirements to remain located there. All parts of the induction process are usually concluded within this time and individuals are allocated to activities. I have asked that the circumstances that led to such a delay in this happening with the man be established as part of our internal investigation. However preliminary findings do indicate that this may have been an oversight associated with a significant increase in receptions to the establishment in February and March. This increase would have created a delay in the Allocations and Labour Board processes as well as prospectively delaying progression off the induction unit.'

197. Given that the man left the induction wing in March, I am satisfied that the lack of purposeful activity during his early days at Stoke Heath was unlikely to have been a factor in his decision to harm himself almost a month later. However, purposeful activity does play a vital role in helping prisoners cope with the position they find themselves in and ensuring their well-being. Because the Governor had already asked his staff to examine this issue following receipt of feedback from my investigator, I did not make a recommendation in the draft report. Following publication of the draft, I am pleased to say that I received the following update from the Stoke Heath management team:

> 'Preliminary findings from the internal investigation indicated that there had been a delay in the allocation of prisoners to activities following an increase in the number of receptions. This caused a backlog of prisoners needing allocation to activities (including gym induction) and, unfortunately, the man was one of those prisoners. HMP Stoke Heath have worked to remedy this situation and can assure the PPO that gym induction now takes place on a daily basis unless operational issues dictate otherwise.
>
> 'The delays, as described above, have a residual effect on the education induction because the process dictates that prisoners cannot

attend one before the other. His 4 day delay was purely the result of the increased number of receptions, a problem which has been removed as per the paragraph above.'

198. The man's family responded to the findings in the draft report. They commented:

> 'The family remain extremely concerned that there was insufficient meaningful activity available to him at Stoke Heath and that this contributed to his death.
>
> 'Further, staff at Woodhill identified lack of meaningful activity as a risk factor when he was subject to ACCT monitoring.'

## CONCLUSION

199. On the basis of the available evidence, I do not consider that the staff at Stoke Heath could reasonably have predicted the man's death. He appeared to have settled into prison life and was talking about his plans for the future. There had been a previous incident at Woodhill involving a ligature almost three months earlier, but ACCT self harm monitoring was used effectively during January and the period of crisis was managed.

200. My investigation has shown a significant contrast between the man's behaviour at Woodhill and Stoke Heath. He had only been in prison for three weeks when he became very distressed and put a ligature around his neck. I consider that the staff at Woodhill showed a commendable degree of concern for him and helped him through a difficult period. His mood then seemed to improve and after his transfer this improvement appeared to continue at Stoke Heath. He never openly expressed upset in the same way that he had done a month or two earlier. We cannot know whether he was genuinely much more content (at least to begin with) at Stoke Heath or whether he made a conscious decision to mask any distress he was feeling.

201. We also cannot know definitively whether the man was bullied at Stoke Heath. There was speculation after he died, but no solid evidence. I think it likely that he interacted with the prisoner, who was a very difficult prisoner and about whom other young men had complained. The proximity of their cells suggests that they spoke. However, I do not reasonably think that the staff on B wing could have intervened without evidence. YOIs hold a lot of troubled young men who might in turn disturb other prisoners. To some extent, this is unavoidable. Nonetheless, I bear in mind the comments of HM Chief Inspector of Prisons and urge the Governor to revisit her remarks that shouting out of windows was 'endemic'.

**The response from the man's family to the draft report**

202. Following the publication of the draft report of the investigation, the man's family wrote to the investigator through their solicitor. They commented:

> 'We regret that the draft Ombudsman's report does not address many of the concerns that the family have about the circumstances of his death.
>
> 'The family remain extremely concerned that there were repeated and significant failures to assess and appreciate the risk that he posed to himself, as well as failures by the various agencies responsible for his care to communicate important information about his vulnerability.
>
> 'The family believe the ACCT was closed prematurely on 11 January 2011. However, they recognise that staff at Woodhill had as a result of the ACCT process gone some way to appreciating his risks in a custodial setting…
>
> 'The family believe the ACCT was again closed prematurely on 19 January 2011… In the family's view, the premature closure of the ACCT meant that the Prison Service missed a significant opportunity to monitor him closely over a sustained period which in their view would have afforded staff more time in which to understand and manage his risks for the remainder of his prison sentence.

203. Although the investigation expressed reservations that the second ACCT document was closed after a week, it is important to bear in mind that this document would not have remained open over two months later, because there was no further indication to staff that the man was thinking about harming himself. The family continue:

> '…there appears to be inadequate investigation of the induction processes at Stoke Heath [by the PPO].
>
> 'The family are concerned that the contemporaneous documents suggest that there were significant errors in the assessments conducted when he was transferred from Woodhill to Stoke Heath…
>
> '…the family are concerned that staff with day to day responsibility for his care on the wings at Stoke Heath had an inadequate understanding of his risk profile.'

204. The family think that staff at Stoke Heath should not have taken what the man told them at face value.

205. The family's solicitor also wrote:

> ‘The man’s family remain extremely concerned that there was insufficient meaningful activity available to him at Stoke Heath and that this contributed to his death.’

206. The family refer to Prison Service Order 2700, which highlights the link between purposeful activity and lower rates of self-inflicted death. Their solicitor writes:

> ‘In the family’s view, the draft report fails to explain what the man’s regime was in the weeks and days immediately preceding his death.
>
> ‘The family… feel there is insufficient consideration of this issue in the draft report…’

207. The family thought that the Ombudsman should have made a recommendation requiring Stoke Heath to ensure that prisoners are provided with sufficient meaningful activity. However, we do think it is significant that, at the time of his death, the man was working for the chaplaincy and had appeared to be performing well in this capacity. The family continue:

> ‘[The family’s] concern that a known bully was located next to him, a prisoner the Prison Service knew or ought to have known was vulnerable, follows on and builds on the concern… that there was insufficient meaningful activity for both of them.’

208. The family thought that the draft report should have recommended that steps were taken across the YOI estate to reduce opportunities for bullying.

209. The man’s family thought that he should have been held in a double and not a single cell to reduce the risk of him taking his own life. However, the vast majority of cells on B wing are single occupancy, and his behaviour at the time of allocation gave the staff no cause for additional concern about his state of mind.

210. The family also record their concern about the effect that being locked up in a small cell had on the man. They thought that he should have been held in a cell which had had obvious ligature points removed. Again, it is important to remember that staff had no reason to think near the time of his death that he was thinking about harming himself. The family wrote:

> ‘In the family’s view, locating him in a cell with obvious ligature points provided him with the means to take his own life and therefore contributed to his death.’

211. The family thought that the Ombudsman should have recommended that urgent steps were taken to make the cells across the YOI estate safer.

212. With regard to the emergency response on 2 April, the man's family commented:

> 'The family agree that once he was found hanging on 2 April 2011 it appears that the response of staff was appropriate.'

213. The family thought that the Head of Healthcare at Stoke Heath should liaise with the local ambulance service to agree a protocol in the event of another emergency callout. They also expressed the hope that the Governor would conduct a review to determine whether the radios used on B wing needed to be replaced.

214. The family's solicitor suggested that the duty governor should have informed the man's mother of her son's death. However, we would reiterate that prison staff are asked to notify the named next of kin. There are good reasons for this. They complied with this requirement at the time of his death and informed his grandmother.

215. We would like to thank the man's family and solicitor for taking the time to provide such a thorough and thoughtful response to the draft report.

## RECOMMENDATIONS

### Stoke Heath

1. The Head of Healthcare should discuss through regional forums the problems that have occurred with the Threshold Assessment Grid referral system, with a view to simplifying the initial reporting form.

   The Head of Healthcare accepted the recommendation and provided the following response:

   'The TAG Assessment is currently being reviewed to ensure that it is both fit for purpose and user friendly. The Head of Healthcare is in consultation with other establishments across the region in order to share best practice and ensure that consistency in format and procedure is achieved. Once the revised assessment tool is agreed all staff will be trained in its completion, the tool will be implemented and a time frame for review will be set.'

2. The Head of Healthcare should remind staff of the need to take into account previous self harm when completing the Threshold Assessment Grid initial assessment.

   The Head of Healthcare accepted the recommendation and provided the following response:

   'This issue will be considered as part of the above consultation. In the interim the Head of Healthcare will remind the staff that historical incidents and/or patterns of self harm need, where information is available, to be considered as part of the initial assessment process. Assessments will be subject to a Quality Assurance check to ensure consistency.'

3. The Head of Healthcare should remind staff to consult the prisoner's clinical record fully during the reception process.

   The Head of Healthcare accepted the recommendation and provided the following response:

   'The Head of Healthcare will remind staff of the need to consult the prisoner's clinical record fully during the reception process. The reception process will be subject to a Quality Assurance check to ensure consistency.'