Investigation into the circumstances surrounding the death of a man at HMP Elmley in December 2010

Report by the Prisons and Probation Ombudsman for England and Wales

February 2012

This is the report of an investigation into the death of a man. He was found hanging in his cell at HMP Elmley in December 2010. At the time of his death he was awaiting sentence, having been convicted two days earlier of the murder of his brother. He was 50 years of age.

I extend my condolences to the man's family. I hope that my report goes some way to answering any questions they may have. I regret that my report has been delayed and apologise for any additional distress that this may have caused to his family.

The investigation was carried out by one of the Ombudsman's investigators. A clinical review was commissioned from the local Primary Care Trust (PCT) into the medical care that the man received whilst in prison custody.

I would also like to take this opportunity to thank all of the staff at Elmley for their cooperation during the investigation.

My investigation has established that, during his time at Elmley, the man was settled, shared a cell with his son and was optimistic over the outcome of his trial. However, his subsequent conviction appears to have had a significantly negative effect upon him. He was concerned that his sentence would be so long that he would die before his release from prison.

My report makes a number of recommendations, the most significant of which relates to the assessment of the man after his conviction and return from court. Given his behaviour in the days leading to his death and his friend's concern for him, I also make a recommendation with regard to the requirement of staff to record all significant interaction and information about a prisoner. However, I conclude that staff could not have reasonably foreseen the actions that he was to take.

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.

Thea Walton
Acting Deputy Ombudsman **February 2012**

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SUMMARY

1. The man was remanded into custody at HMP Elmley on 2 January 2010, having been charged with the murder of his brother several days earlier. During the first days of custody he was assessed by healthcare staff on a number of occasions, including by members of the prison's mental health team. During his contact with mental health staff, he provided no evidence that he was suicidal or at risk of harming himself. Over the following months he was treated for a number of physical ailments, including asthma, backache and chest pain.

2. Having spent a brief period of time at HMP Highdown, the man was transferred back to Elmley on 9 April. He made a request to share a cell with his son, who had received a similar charge to his own, and this was granted.

3. Over the summer months the man complained on a number of occasions about chest pains and palpitations. A number of ECG tests were undertaken, the results of which were normal. (An ECG or electrocardiogram is a test that records the rhythm and electrical activity of the heart. It is commonly used to detect and assess problems of the heart.) He was advised on a number of occasions that his heart activity was normal. Given that his ECG tests were normal, the prison doctor decided there was no need for a cardiological (heart) referral to be made to an outside hospital.

4. Having attended court on a number of occasions during his time at the prison, the man's trial started on 4 October. On each day that he attended court he was assessed by healthcare staff when he left the prison each morning and on his return in the evening. During each of these assessments no indication was made to staff that he was either at risk of suicide or had any thoughts of harming himself. The records suggest that he remained optimistic with regard to the outcome of his trial.

5. On 10 December, the man was convicted of the murder of his brother. On his return from court, he was assessed by a nurse in reception. The nurse recorded in his medical record that he faced a lengthy sentence, was worried about his son, but no other concerns were raised. However, his son, who was also facing trial and shared a cell with his father whilst in custody, described him as being "distraught" by the outcome.

6. During prison visiting time the following day, a friend of the man reported to staff that he had stopped taking his medication and that he said he was going to take an overdose. However, the officers on duty said that they were told that he had just stopped taking his medication. They alerted an acting senior officer on his houseblock and he was seen by the officer on his return from the visit. He told the officer that he was fine and had no problems.

7. Over the following days the man's behaviour appeared to deteriorate. Although he continued to participate in prison life as normal and regularly spoke with members of his family on the telephone, he seemed to become withdrawn. He attended chapel as usual but returned to his cell immediately

after the service had ended. That afternoon, shortly before attending a visit his son saw him ripping bed sheets in his cell. He told him that he was making a washing line.

8. At approximately 3.05pm the man was found by an officer hanging in his cell. The alarm was raised and, despite a brief delay due to the cell being barricaded, staff entered the cell. They cut him down and immediately started cardio pulmonary resuscitation (CPR). Paramedics arrived at 3.44pm and he was pronounced dead shortly after.

9. As a consequence of my investigation my report makes four recommendations. The most significant of which relates to the assessment of the man by healthcare staff on his return from court, having been convicted earlier that day. I also make recommendations with regard to the calling of the ambulance service, ACCT training and the importance of staff to record pertinent information about prisoners in the relevant records.

THE INVESTIGATION PROCESS

10. The investigation following the man's death was carried out by one of my investigators. Another of my investigators opened the investigation on 16 December 2010 when she visited HMP Elmley. She met with the Governor of Elmley and the Head of Safety and Decency, as well as other members of staff at the prison. She also met a representative from the Prison Officers' Association (POA) and a member of the Independent Monitoring Board (IMB). (The POA is the trade union for prison officers. IMB members are independent and unpaid. They monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained.)

11. Notices announcing the investigation and its terms of reference were issued to both staff and prisoners at Elmley. The notices were displayed around the prison and invited staff and prisoners to contact my investigator with any information relevant to the investigation. No-one came forward to speak with the investigator.

12. However, my investigator did speak with the man's two sons, one of whom shared a cell with him in Elmley. The investigator also spoke with a prisoner who had previously shared a cell with him whilst at the prison and with a friend of his, who had visited him on the day before his death. However, my investigator was unable to speak with two other prisoners who provided information after the death of the man, one due to their unavailability and the other as a consequence of a transfer to another establishment.

13. My investigator visited the cell and wing where the man spent the last weeks of his life. The investigator reviewed his prison and health records and other documentation relating to the time that he spent at Elmley, and subsequently visited the prison on several occasions to interview staff. During the course of the investigation my investigator provided verbal and written feedback to the Governor. My investigator also had access to transcripts of telephone calls made by the man to members of his family. (The content of these telephone calls were not known to staff before his death. Although they are recorded, only a small percentage of telephone calls made by prisoners are monitored. When calls are monitored they are usually for reasons of security or child protection. He did not fall into either of these categories.)

14. A clinical review was commissioned from the local Primary Care Trust (PCT). The clinical reviewer completed this on behalf of the PCT and I am very grateful for his assistance in this matter.

15. The investigator also liaised with Elmley's police liaison officer and with a DI from Kent Police, who is acting on behalf of Her Majesty's Coroner for Mid Kent and Medway. A copy of this report will be sent to the coroner to assist her with her enquiries.

16. One of my family liaison officers contacted the man's wife and two of his sons to discuss the purpose and scope of the investigation and to give them the opportunity to raise any questions or concerns they had about his death. On

26 January 2011, my family liaison officer and investigator met with the man's sons at HMP Swaleside. During the meeting they raised a number of concerns. These included

- The level of support their father received on his return from court on the day of his conviction. Their understanding was that having been convicted their father did not see a member of the healthcare team and that there was no subsequent monitoring of his father by staff.

- They also commented that staff at Elmley appeared less knowledgeable in comparison to their counterparts at Swaleside. They said the level of care and support at Elmley appeared limited due to it being a remand prison, expressing their surprise that no one went to talk to their father after his conviction.

17. During the meeting, the man's son, who shared a cell with his father in Elmley in the months before his death, said that his father had problems with his cholesterol and suffered from a number of other ailments including high blood pressure and a slipped disc. He said that his father's health seemed to worsen whilst in prison, for which he took medication including pain killers. He said that his father's main issue appeared to be with pains he experienced in his chest. His son said that before he and his father were remanded into custody his father had told the family that he had seen his doctor who had told him that there was a one in ten chance that he would die from the condition he had. He did not know what condition his father had. He said that whilst his father was in prison he did not receive any help to improve his conditions. He told my investigator that his father's doctor had said that he needed to improve his diet and that there had been an occasion when his blood pressure had been "sky high".

18. I hope that my report addresses the family's concerns and helps them better understand what happened to the man in the time leading to his death.

Following the draft report consultation process the man's family raised a number of issues which have been subsequently addressed by this office in separate correspondence.

HMP ELMLEY

19. HMP Elmley, opened in 1992, is a local prison serving Kent and many of the courts in the county. It is one of three prisons that make up the Isle of Sheppey prison cluster. The prison has an operating capacity of 1252 and holds both remand and sentenced prisoners. The prison consists of six residential houseblocks, a healthcare unit and segregation unit.

20. The man's death is the first apparently self-inflicted death in Elmley to have taken place at the prison since April 2009, and that death followed two earlier self inflicted deaths in 2008. I repeat a recommendation with regard to the recording of relevant information, made in one of those deaths, in this report into his death.

Her Majesty's Chief Inspector of Prisons

21. The last inspection of Elmley, by the then Her Majesty's Chief Inspector of Prisons was an unannounced short follow up inspection of the prison in April 2009. She reported that overall:

> "There had been some progress since our last inspection and the prison was slightly less crowded … Aspects of work to ensure safety had improved, although we remained very concerned by the arrangements to manage prisoners at risk of suicide or self-harm."

22. She also reported that "Records in prisoner wing files were of limited value and most entries were merely about warnings given".

23. In my report into the man's death I comment on ACCT training. (ACCT procedures are used to assess, observe and support prisoners who are at risk of harming themselves. They highlight problems and possible trigger points of a prisoner at risk of harming himself and make a multidisciplinary plan to give support and help through a period of crisis.) I note that in the report of her inspection the Chief Inspector comments on the same issue:

> "There was evidence of frequent and ongoing training for prison staff, but not all agency staff in the health services department had been trained in ACCT procedures."

24. In her report the Chief Inspector made a further recommendation that, "Agency nurses should complete assessment, care in custody and teamwork (ACCT) training". I make a similar recommendation in this report.

Independent Monitoring Board

25. The last Independent Monitoring Board report for Elmley was for the period 2009 to 2010. They do not comment on any matters directly related to the man's death.

KEY EVENTS

26. On 31 December 2009, the man was arrested and taken into police custody on suspicion of the murder of his brother on 27 December. His wife and two of his sons were also charged and remanded into prison custody for a number of offences against his brother. He had previously been imprisoned for a period of three months in 1983.

27. He appeared at Magistrates Court on 2 January 2010, and was remanded into prison custody at HMP Elmley. On his arrival in reception staff recorded the man's personal details on page 1 of his Core Record F2050 (a reception document completed for all new prisoners). He undertook a first night induction at which various aspects of prison life were explained and further general personal data was recorded.

28. During the reception process the man told staff that he did not feel suicidal, had not harmed himself, and had no plans to do so. A cell sharing risk assessment (CSRA) was completed. (A CSRA is an assessment used to determine the risk that a prisoner would present to others when sharing a cell.) It was recorded that he had no history of harming himself and no other concerns about his safety had been raised. He was assessed as being at low risk of assaulting a cellmate.

29. During the reception process the man was given a first reception health screen by one of the prison's nurses. (All prisoners are given a first reception health screen when entering prison. The aim of the screen is to identify any health concerns or needs that the prisoner might have. It includes identifying a prisoner's past medical history, including mental health.) The nurse noted during the review that he was:

> "...settled, relaxed and body posture was open through the interview, maintained good eye contact. Denies current thoughts or history of deliberate self harm…"

30. The following day, the man was assessed by one of the prison's doctors as part of the initial health screen process. The doctor noted that he had no history of mental illness or had any thoughts of either suicide or of harming himself. During the assessment he complained of back pain and arthritis for which he was prescribed Diclofenac, an anti-inflammatory medication, and Co-Codamol for the relief of the associated pain. The doctor told him that he also suffered from high cholesterol.

31. The man was re-prescribed other medications for which he had been provided in the community including Perindopril, used for the lowering of blood pressure and Lansoprazole, used for the treatment of stomach irritations. He also told the doctor of hearing difficulties and a family history of ischemic heart disease and diabetes. (Ischemic heart disease is a condition of the heart where the heart muscles are damaged or do not work as efficiently due to a reduced blood supply to the heart. The risk of getting this disease increases with age, and is more prevalent among smokers than non-

smokers. Also at risk are people with diabetes, high blood cholesterol levels, high blood pressure, and individuals who have family history of the disease.)

32. On 15 January, in consultation with one of the prison's doctors, and as a consequence of a request by the man, his prescription of Co-Codamol was changed to Co-Dydramol, also an analgesic used for the treatment of mild to moderate pain relief. He was risk assessed as being able to hold all of his medications in his own possession. (Prisoners are able to hold their own medication in possession after a risk assessment by healthcare staff. The risk assessment assesses whether a prisoner is likely to abuse the trust given to them to hold their own mediations. This includes whether they will trade the drugs to other prisoners and the possibility that they may harm themselves by, for and example, an overdose.)

33. The man was assessed by a Registered Mental Health Nurse (RMN), a member of the prison's mental health team, on 4 January. She noted in his medical record that he was engaging, pleasant and appropriate throughout the assessment. The nurse recorded that there were no mental health concerns and he denied any thoughts of suicide. As a consequence, he was discharged from the care of the primary mental health team.

34. As he had appeared at court on 21 January, the man was transferred to HMP Highdown. My investigator has been unable to establish why he did not return to Elmley. On his arrival at Highdown, he was provided with an induction and assessment by the prison doctor. During his short time at Highdown, he was referred to hospital regarding his hearing difficulties and to the prison's asthma clinic.

35. The man was transferred back to Elmley on 9 April. During the reception health screen a nurse noted that he was currently in receipt of a number of medications for previously diagnosed conditions. The nurse also noted that he suffered from hearing problems and asked for Co-Codamol to assist with associated pain. He was again assessed as suitable for in-possession medication. The records show that it was noted again that he had no mental health issues or expressed any suicidal intent. He requested to share a cell with his son. This was granted.

36. On 13 April, the man was provided with two further inhalers for the treatment of his asthma, Salbutamol and Beclometasone. (More commonly known as Bronchodilators these drugs work by opening up the air passages in the lungs so that air can flow into the lungs more freely. In doing so they help to relieve symptoms such as coughing, wheezing and shortness of breath and are used in the treatment of asthma.) At a medication review on 15 April, he again expressed no suicidal intent or thoughts to harm himself. At the review the prison doctor also prescribed Amlodipine, another drug used in the treatment of high blood pressure.

37. On 24 April, the man was referred to the optician and the hospital regarding the repair of his hearing aid. He was re-prescribed Simvastatin, used in the lowering of cholesterol, a drug that he told the doctor he had previously been

prescribed.

38. Prison Doctor A saw the man on 11 May as he complained of chest pains. He said he had suffered from them for two months and his asthma inhaler provided some relief. The doctor made arrangements for an ECG and blood tests to be taken. (An ECG or electrocardiogram is a test that records the rhythm and electrical activity of the heart. It is commonly used to detect and assess problems of the heart.) Two days later on 13 May, he reported to a nurse and again complained of chest pains. An ECG was undertaken. The results showed normal sinus rhythm (indicating the regular and normal activity of the heart) and appropriate blood pressure.

39. The man was assessed further by medical staff on 14 May. Another ECG test found that his heart activity continued to be normal. As a consequence of his complaints of tightness across his chest, he was provided with GTN spray and advised to tell staff immediately should the symptoms persist. (Glyceryl Trinitrate, more commonly known as GTN, is used to relieve the symptoms of angina and other heart pains. It works by enlarging the blood vessels of the heart, thereby increasing blood flow to the heart. This usually relieves the pain of angina quickly.)

40. The man saw Prison Doctor A again on 27 May. He complained of continued chest pain and palpitations. Another ECG was taken which showed no concern. In the medical notes the doctor raised the possibility of a 24 hour ECG taking place. (A 24-hour ECG helps to diagnose symptoms, such as palpitations, which only happen now and again. Sometimes it can show up an abnormal heart rhythm that might need further treatment. It can also help to reassure patients if the results are normal.)

41. During a consultation for a knee injury on 30 June, the man was told by Prison Doctor A that there had been an increase in his cholesterol. The doctor also said that a cardiological (heart) referral would be made with regard to his continued palpitations. On 16 July, he enquired as to why he had not been referred to the cardiologist for an ECG during a consultation with a nurse. The nurse made enquiries with Prison Doctor B who advised that, given the results of the ECG were normal, there was no need for a referral to the cardiologist at that time. Over the following weeks, he was also assessed with regard to his hearing and a referral for further treatment was made to the Audiology Department at hospital.

42. During their interviews with my investigator many staff at the prison described the man as an outgoing person who mixed well and was popular with other prisoners on the houseblock. An ASO described him as:

> "… a very sort of happy go lucky kind of guy, very jovial with staff and his peers. He was always having a laugh and a joke and was very much the centre of attention with a lot of other prisoners… "

43. Whilst at Elmley, the man attended court on a number of occasions. His trial started on 4 October. On each occasion of his transfer to court there was

nothing recorded to indicate that staff thought that he was either at risk of suicide or had any thoughts of harming himself. During his appearances at court, he was seen daily in reception, on his departure and return from court, by healthcare staff. A nurse, who during this time worked regularly in reception and saw him daily, described him as "quite optimistic" and said:

> "From the beginning of the court case he remained pretty predictable he was quite assured that the case was going to, for want of a better word, be dropped, or it was going to be a not guilty plea, a not guilty verdict, it was going to be overturned."

44. During his trial, the man was also seen regularly in reception by Officer A as he left and returned from court each day. She described him as one of the few prisoners to stand out because he was polite and had good manners. She described him as being:

> "… a very jolly character. After a week of being processed through reception and going to court every day he knew the process, he knew which sheet to sign for his property, he knew which area he needed to be strip searched in. He was going through the motions but he was happy to do so paperwork-wise. Yes he was very talkative, very chatty, very well presented."

45. Another officer who knew the man described him as:

> "… very polite, fairly jovial, he was just a nice person … He caused and raised no concerns with myself when I dealt with him, he was just a normal, just seemed to be getting on with life as it had been dealt to him at the time."

46. On 4 November, on his return from court, the man was seen by a Practice Nurse. The nurse reported that he had said he felt unwell. He said his heart was racing and that he had been experiencing chest pains. The nurse reported that he appeared anxious. Unable to perform an ECG at that time, due to missing electrode pads (sensor pads applied to the skin), he returned to his cell. (I understand that in light of his death the Head of Healthcare reported on the circumstances surrounding his death. With regard to this incident it was established that the "… necessary equipment was available in the room that the offender [the man] was examined to carry out this procedure." And the Head of Healthcare goes on to report that "This aspect had been dealt with by the individual's line manager.")

47. The man was seen by a doctor on 6 November, who recommended that another ECG and Event Recorder take place. (An Event Recorder, (some of which are portable), is a type of ECG, and is used if symptoms in a patient are less frequent. They can record the heart's activity for a longer period of time than an ECG or can be used whenever symptoms occur.)

48. On 10 December, the man, with two of his sons, was found guilty of murder at Crown Court. His wife was found guilty of causing grievous bodily harm.

The son, with whom he shared a cell at Elmley in the months before his death, said that his father was distraught at being convicted, and had thought that he would be found innocent. He said that escort staff provided tissues for his father and, on his return to the prison, interaction with staff had been brief. He said that his father spent about two or three minutes with the nurse on his return from court adding that none of the other staff on duty asked him anything.

49. According to the Person Escort Form (PER), the man arrived back at Elmley at 6.00pm. (The PER is a form that accompanies prisoners on all journeys from and between prisons. It serves as a communication tool about risks a prisoner poses on escort or transfer. It also provides a chronological record of the escort, meals served and timings of the journey.) There was nothing on the PER to indicate that he was at risk of harming himself.

50. The man's son told my investigator that his father left the escort vehicle first and was put into one of the reception units holding rooms (a room in which prisoners are placed before their paperwork is processed). He said that his father went into the holding room for a few seconds before he was taken to be searched. He said that he spoke briefly with an officer and nurse behind the reception desk before returning to the wing with his father.

51. Officer A told my investigator:

> "We knew at some point there would be a result that day regarding them so before he came back from court that day we were made aware that they had been convicted and how long they were possibly looking at. So all the staff in reception were aware and the nurse that evening was made aware that he would be one of the prisoners he needed to see that night."

52. The man was seen by a Registered Mental Health Nurse (RMN). She wrote in his medical record:

> "Seen in reception back from court stated that he was facing a lengthy sentence will be sentenced on Wednesday worried about his son, states that he can handle it. No concerns raised."

53. The nurse told my investigator that because there had been a change in the man's circumstances she assessed him in the nurses' room in reception. She said that his:

> "… presentation was more or less the same as the previous outings. There wasn't any distress with him as such. There were no concerns. I mean nothing came, you know to light … although I didn't document it he wanted his son to be moved into healthcare. He had more concerns about the son rather than himself … at the end of the assessment it was more us discussing about [his son] rather than him."

54. The nurse said that the man: "… didn't display any self-harm ideation or suicide ideation … There wasn't any inkling to suggest that he was in distress".

55. Officer A saw the man whilst he was collecting his meal in reception. She told my investigator that she asked him how things had gone at court. She said:

> "… he was just I think a little bit shocked, still as talkative but there wasn't and upbeat tone to his voice and I think he was still in the shock of the disbelief of the actual sentence that he was possibly looking at because he was adamant that he was innocent."

56. My investigator asked the officer if she had thought the man was at risk of harming himself and whether there were any concerns which would have led to the beginning of Assessment, Care in Custody and Teamwork (ACCT) procedures. (ACCT procedures are used to assess, observe and support prisoners who are at risk of harming themselves. They highlight problems and possible trigger points of a prisoner at risk of harming himself and make a multidisciplinary plan to give support and help through a period of crisis.) She said:

> "He didn't give that impression. He answered everything, all the questions that I asked him, he gave me eye contact, he didn't try to avoid any issues, his interaction was still as good as it would have been before his conviction or it was before his conviction."

57. At 7.29pm, the man made a brief telephone call to his sister. During their conversation they discussed the verdict given at court earlier that day and the possible length of any sentence.

58. Acting Senior Officer (ASO) A said that he knew that the man had been convicted that day. However, he told my investigator that he could not recall how he knew.

59. My investigator asked the man's son if his father had said anything that concerned him or had talked about the events of that day. His son said that after arriving at the prison late on the Friday they had collected their evening meal. He explained that they picked at their food. He said that his father did not really say anything that evening and that they watched the evening news, on which their court case had featured. He told my investigator that during the evening he could hear his father crying. He said that they then turned the television off in order to try and sleep.

60. On the morning of 11 December, at 9.26am, the man made another telephone call to his sister. They again talked of the trial and possible sentencing.

61. The man's son told my investigator that on the Saturday morning his father, "had not appeared himself". He said that his father was already up when he

awoke and was reading the bible, but noted that his father regularly read the bible and attended church. He said that his father appeared distant, did not want to engage and was rather lethargic. He said that in preparation for visits that afternoon his father had washed and put on his "normal clothes".

62. That afternoon, at around 3.00pm, the man received a visit from a friend and other members of his family. The friend told my investigator that the visit that afternoon was "very traumatic". He said that it was the day after the man's and his son's convictions. The friend said that it was a "bad visit" and the man cried the whole time. He said that the man had said that he could not believe that members of his family had told lies and given evidence against him.

63. The man's friend told my investigator that during the visit the man had said that he had stopped taking his medication and was saving it up in order to take an overdose. The friend said that the man had said he was feeling suicidal and talked about matters after his death. In particular, he mentioned that the insurance on a van or lorry he owned should be able to pay for his funeral expenses.

64. The man's friend said that he informed two officers on duty in the visits hall about his conversation with him. My investigator later identified one of these officers as Officer B. The friend said that the officers said they would let the senior officer on the man's houseblock know the content of the conversation. One of the officers later informed the man's friend that the houseblock had been contacted and that ASO A would call the man in for a chat when he returned from the visit.

65. However, Officer B remembered his conversation with the man's friend differently. He recorded in his note book that he was approached by a gentleman in the visits hall. He said that the man told him that the man had an illness and, as his doctor had said he only had eight to nine years to live, he was going to stop taking his medication. He said that he advised the friend that the prison could not force the man to take his medication. However, he said that he told him that he would ring the man's houseblock and ask the senior officer to have a chat with him on his return. He said that he then spoke to ASO A on houseblock four, and advised him of the conversation. He said that the ASO confirmed that he would speak with the man. He said he told the friend, when he was leaving the visit hall, that he had notified the wing staff and that at no point did the friend mention to him that the man was feeling suicidal.

66. ASO A confirmed that he spoke to the officer who informed him that the man's family were concerned that he had stopped taking his medication. He said that he spoke with the man on his return to the houseblock. He told my investigator that:

> "As he came through I'd noticed that he'd returned and asked him, called him into the office and he sat down and basically asked him if he had any concerns, any issues you know. I didn't inform him that his

family had any issues at the time. It was just a case that you know I've been asked to have a chat with you and make sure everything is okay and in my professional opinion I believed there was no concerns. He was happy, he was fine I'm fine governor, no problems and I said okay, thanks very much."

67. At around 4.35pm, the ASO unlocked the man from his cell so he could make a telephone call to his sister. During the telephone call she asked how his visit that afternoon had gone. He told her that it had been difficult. He went on to discuss his possible sentence. He also talked with his sister of potential appeals and the possibility of a retrial.

68. The man's son said that after his father returned to the cell having made the telephone call. He said he then collected his evening meal and retuned to the cell by 5.00pm. He said that his father made no mention of any staff speaking to him following his visit.

69. On the morning of 12 December, the man's son told my investigator that his father had got ready to attend church that morning but had not eaten his breakfast. At 9.11am, he made a further telephone call to his sister in which he again talked of the possibility of an appeal. At one point during the telephone conversation he said: "I'll be dead now by the time I come out…" and a couple of sentences later said: "What's the point now, the next time you see me is in the box." His sister responded by saying: "No it won't, we'll, don't be like that … you just gotta hold strong." He went on to say that if he received a sentence of twenty years he would not be coming out, adding that "… the old heart won't take it. But it will have to try to but it won't."

70. Speaking to another relative in a further telephone conversation the man said "I'm, er, brown bread again." (this can be known as slang for dead). His son said that his father had been on the telephone for "quite a while" that day. At 10.03am, he spoke with his son's fiancée on the telephone. He asked her to organise for letters to be sent to the judge for sentencing the following Wednesday. They talked about the appeals process and seeking new legal representation.

71. The man's son said that at about 10.15am he and his father both went to church. Officer B was detailed to assist in the chapel that Sunday. He said that he asked how they both were and they had replied that they were fine. He said that after church his father normally mixed with other prisoners and staff. However, he said that on this day his father did not wait for him but returned straight to his cell. He said that he returned to the houseblock at approx 11.30am and went to collect his lunch at around midday.

72. The man's son said that he got ready for his visit with his fiancée that afternoon. He said that his father normally went to a prisoners meeting on Sundays but he had said he was not going to attend. He said that as he left the cell his father had asked him to leave the door open. He said that he went downstairs and was queuing for his visit when his father leaned over the banister and asked if the telephones would be on at 1.45pm.

73. The man's son told my investigator that as he was waiting he had spoken to another prisoner and had asked if he would be able to use his toilet if his own cell door was locked. He said that he ran upstairs to use his toilet but found his cell door locked. He said the viewing flap was open and upon looking inside he saw his father ripping up a bed sheet. He said he asked his father what he was doing and that his father had replied that he was "making a washing line". He said that he then went back downstairs to attend his visit and said that he asked the prisoner to whom he had been talking to keep an eye on his father.

74. At 1.51pm, the man was given permission by ASO A to make a telephone call to his sister, during which he again talked about the possible length of his sentence. At one stage during the conversation, he said that if he did not get out of prison in the next nine years he, "…ain't coming out…", he added that his belief was that the judge was going to give him a 30 year sentence. He ended the telephone call to his sister similarly to his other phone calls, exchanging their love and saying that they would speak later. He returned to his cell at around 2.15pm.

75. My investigator spoke with a prisoner who knew the man and had previously shared a cell with him and his son. He described him as a "closed shop", "real soldier" and someone who had a "poker face". He said he was a religious man who regularly attended church services. The prisoner told my investigator that the man would often say that "…he could not do the time" and that the doctor had only given him 10 years to live due to his heart and respiratory problems. He explained how the man thought his sentence would be longer than the length of his natural life and so he was not prepared to serve a possible 20 to 25 year sentence. He said the man was shocked at having been convicted.

76. On the day of the man's death the prisoner said that the man had asked him for a chair from his cell. He said that the man's head "was down" and he did not make eye contact. The prisoner said that, just before his visit, the man's son returned to the landing to use the toilet and, as his own cell door had been locked, asked to use the toilet in his cell. He also said that the man had, "loads" of medication in his cell and that he took the medication as and when necessary.

77. At 3.05pm, ASO A, whilst unlocking the wing for afternoon association, was unable to open the man's cell door. (Association is when prisoners are let out of their cell to associate with other prisoners, make telephone calls, have showers and carry out other personal tasks.) He looked through the observation hatch but the cell was dark and he could see little. He attempted to push the door open again and looked through the hatch. He saw that the man appeared to be standing in the middle of cell. He said he called out several times but there was no response from him.

78. The ASO called for help. Officer C, who was standing nearby, said that the ASO looked confused and said that he could not get the door open while the

man was just stood there. On looking into the cell the officer saw that, although his view was slightly obscured, the man appeared to be hanging from the cell's light fitting. At approximately 3.07pm, he radioed for assistance calling, "urgent message Code Blue HB4". (This is an emergency call sign to indicate that a person has breathing or respiratory problems. The code allows the medical staff in the prison to respond immediately with the appropriate emergency equipment.)

79. The officers were immediately joined by Officer D who, with Officer C, tried to gain entry by kicking the cell door as it had been established that the cell had been barricaded by an upturned table. The ASO left to fetch the anti-barricade key from the wing office. (An anti-barricade key is one which releases the cells hinges from the outside thus enabling the cell door to open outwards.)

80. Officer D attempted to move the barricade but was unable to do so. However, another officer attended and managed to free the table slightly from behind the door which enabled two other officers to force the door open. The three officers then entered the cell. Two officers took the weight of the man, while the other cut the ligature free from around his neck. One officer said that he and Officer D initially put him on the top bunk before manoeuvring him onto the cell's single bed. (The man and his son were in a cell for three people, although they were the only people in it.)

81. A nurse, the emergency response nurse, said he heard the code blue alarm at 3.07pm and arrived at the cell as the officers were forcing the door open. At 3.09pm, he made a further emergency call for assistance by all available nurses. He said that when he went into the cell he checked the man for signs of life. The nurse was unable to find a pulse and noticed that his pupils were fixed and dilated and both his lips and finger tips were blue.

82. With the assistance of an officer, the nurse immediately started cardio pulmonary resuscitation. (CPR is a procedure used when a patient's heart stops beating and breathing stops. It can involve compressions of the chest or electrical shocks, delivered by a defibrillator, along with rescue breathing.) The officer began CPR without the assistance of a face mask (a device that provides a safety barrier between rescuer and victim when carrying out CPR). During this time, vomit entered the man's airway several times and the procedure was stopped whilst his airway was cleared. CPR was carried out while he was on the cell's single bed.

83. The nurse attached a defibrillator (a machine that treats victims of sudden cardiac arrest by delivering a shock to the heart), and paused regularly during CPR to obtain a reading from the defibrillator machine. At no point did the defibrillator advise that a shock should be applied (to restart the heart) and as such staff continued with CPR.

84. The nurse asked for an ambulance to be called at 3.11pm, so Officer D asked the communications room to undertake this. The nurse, assisted by staff, continued with CPR until the arrival of the paramedics at 3.44pm. (The

Ambulance Service records show that the emergency call was made at 3.16pm.) On their arrival, the paramedics decided to discontinue CPR and the man was pronounced dead at 3.46pm. I understand that the delay in the ambulance arriving at Elmley was caused by it going, in error, to HMP Swaleside first.

85. At the time of the attempted resuscitation the man's son had finished his visit and was making his way back to houseblock. He told my investigator that he saw an ambulance and remembered thinking that it was "strange". He said that he was taken by two officers to the healthcare unit at the prison, where he was informed of his father's death. The man's wife, who was imprisoned at another prison, and other family members were also told of his death that afternoon and evening.

86. A hot debrief was held for all members of staff who had been involved in the finding of the man that afternoon. (A hot-debrief is a meeting held as soon as possible after a major incident to ensure the welfare of staff.) All of the staff that my investigator spoke with said that they had felt well supported by the care and welfare team at the prison. Some members expressed particular satisfaction with the support offered.

87. Following the man's death, a number of prisoners who knew him and his family came forward offering support to his son should he require it. One such prisoner also told staff, after the death, that he knew he would try to kill himself and he could see that it was going to happen. Another prisoner told staff that the man had told him that he would take an overdose and that he had informed staff. However, my investigator has been unable to establish any evidence to indicate staff had been made aware of such concerns.

Post mortem

88. A post mortem was conducted on the man. The pathologist concluded that the cause of death had been by suspension. He commented that the death was not due to natural causes. He also noted that high (above therapeutic) levels of Quetiapine (an anti-psychotic medication) and Mirtazapine (an anti-depressant medication) as well as paracetamol were detected in the blood.

ISSUES

Clinical Care

Management of the man's chest pains

89. In his review, the clinical reviewer says with regard to the man's general health needs: "In general, it seems that individual clinicians had worked conscientiously…" and "every effort had been made to resuscitate him… ". However, he expressed concern: " … that the management of his palpitations and chest pain could have been much better coordinated."

90. The clinical reviewer reports that:

> "The man repeatedly complained of chest pain and palpitations. The description of the pain in the notes is not characteristically cardiac, but he does have a family history of ischaemic hart disease. He also has a history of high blood pressure and high cholesterol."

91. (The clinical reviewer notes that, although the post mortem did not show any damage to the heart, there was evidence of a build up of cholesterol.) With regard to the investigation into the man's complaints of palpitations, the clinical reviewer writes it was:

> " … disappointing that after he [the man] had been told he was to be referred for a cardiological opinion, the referral was apparently overlooked and also, on the basis of a normal ECG, another doctor advised the referral was unnecessary. It seems that the patient was seen by several different clinicians and there was no overall plan. A normal ECG does not rule out angina."

92. In conclusion the clinical reviewer makes no recommendations but says that in his view:

> "… an exercise ECG, perhaps arranged as a rapid access chest pain clinic referral would have offered a better assessment of his possible angina. It might have offered a path for further investigation or possibly could have helped rule the diagnosis out."

93. However, he concludes that these problems were unrelated to the man's death by hanging.

The man's review by the reception nurse on his return from court on 10 December

94. Prison Service Order 2700, Reception, section 6.8, Transfers, Court Returns and other Receptions says:

> "A local protocol must be in operation to screen those prisoners received on transfer, returned from court, or who have a change of

> status, for the risk of suicide and/or self-harm. All such prisoners must be seen by a member of the healthcare team on reception and an appropriate entry made in the clinical record… "

95. Elmley's Reception Healthcare Policy sets out the procedures to be followed by nursing staff when a prisoner returns to the prison following conviction. It says that any prisoners with a change in circumstance must by seen by the reception nurse:

> "The reception nurse will carry out a comprehensive mental state assessment recorded on Emis. [The prisoner's electronic medical record]."

96. Elmley's 'Know Your Job Sheet for Reception Nurses' reiterates this instruction:

> "The reception nurse will see all offenders upon their return from court when their circumstances have changed whether this be Judges remand, have received a finite custodial sentence or if they are a serving offender … The purpose of this is to carry out a comprehensive mental health assessment in order to ascertain whether or not they are a risk to themselves, a risk to other offender or indeed of the likelihood of their mental health deteriorating. It there is as a result of the assessment concerns regards there safety then discussion should be initiated with senior managers re immediate care and management. If there are no immediate concerns but a fuller assessment would be desirable then refer to primary mental health… "

97. Due to the nature of the man's offence, and his conviction that day, he was seen by a nurse in reception on his return to the prison. (It is recognised that those who return to the prison and whose circumstances have changed, such as having been convicted, are more prone to the risk of suicide or self harm.) The nurse told my investigator, and made a record in the medical record, that no concerns were raised other than that he was worried about his son. Although he was assessed by the nurse on his return from court no in-depth mental health assessment or referral to the mental health team was made.

98. As a consequence of the man's death, the Head of Healthcare conducted a review of the healthcare provided by the prison to him. In that report the Head of Healthcare raised concerns over the adequacy of the healthcare screen by the nurse working in reception on the evening of 10 December. The Healthcare Manger concluded that:

> "The documentation of the night of the 10th was inadequate in terms of identifying whether a full mental health assessment was carried out and whether any risks [were] identified."

99. I agree with the Head of Healthcare's findings and endorse Elmley's own recommendation that:

The Head of Healthcare should adopt an additional screening tool/template at the prison to meet the needs of prisoners who have experienced a change in their circumstances, to ensure that all aspects of a mental health assessment are clearly reflected upon.

Delay in calling an ambulance

100. The emergency response nurse arrived, in response to the emergency call for assistance, at the man's cell at 3.09pm, approximately two minutes after he had been found. However, the prison records reveal that an ambulance was not called until 3.11pm (the ambulance service timed the call at 3.16pm). During the investigation my investigator learnt that there was some confusion amongst staff as to who could call an ambulance. One of the officers told my investigator that nurses at the prison made the decision as to whether an ambulance is required to be called to an emergency.

101. I do not believe that the delay in calling the ambulance had any impact upon the man. However, it is essential that staff are reminded that any individual has the authority to call an emergency ambulance. Indeed in a letter from 2006 to Governors from the Director of Prison Health, governors are reminded that, not only should a protocol exist to facilitate immediate access to paramedic services, but the letter also advises:

> "It is also essential that internal procedures should not waste undue time in summoning emergency assistance. It should not; for example, be a requirement in every case for a member of the Health Team to attend the scene before Emergency Services are called. However, a subsequent 999 call to the Ambulance Service should be made to cancel the response, if after the original 999 call has been made; a member of the Health Care Team arrives with the patient and deems that an emergency ambulance response is not required."

The Governor and Healthcare Manager should ensure that a local protocol is in place that provides clear advice about situations in which the ambulance service should be called.

Resuscitation

102. Although the clinical reviewer said that every effort had been made by staff to resuscitate the man, I note that CPR was performed whilst he was lying on a single bed. I appreciate that the cell was small and that there was little space. However, although I am not a clinician, the experience of this office has led me to comment previously that this is not ideal. My understanding is that CPR is likely to be more successful if carried out on a hard flat surface, such as the floor. Although I make no formal recommendation I would ask the Head of Healthcare to remind nursing and other CPR trained staff of this.

103. I also note that an officer did not have access to a face mask whilst conducting CPR. As a consequence he was forced into having to clean his

mouth during mouth to mouth resuscitation. The officer should be commended for his actions in continuing to assist with CPR despite his own personal discomfort. Again I make no formal recommendation but would ask the Head of Healthcare to ensure that all those with CPR training are given access to face masks should they require them.

Unprescribed drugs detected in the man's system after his death

104. In his clinical review the clinical reviewer comments on the findings of the toxicology tests completed on the man during the post mortem. He says:

> "The toxicology report reveals the presence of large quantities of paracetamol in the blood. He had been prescribed eighty four dihydrocodeine and paracetamol tablets about a week before he died. In addition there were high concentrations of mirtazapine – an antidepressant and quetiapine – an anti-psychotic in his blood. There is no evidence that these had been prescribed for him and his mental state examination had previously found nothing abnormal. Such high doses of medication must have had an effect on his mental state and judgement in the time leading up to his death by hanging."

105. My investigator has been unable to establish how the man obtained the drugs which had not been prescribed to him. However, such drugs can be held in possession by prisoners. (Prisoners are able to hold their own medication in possession after a risk assessment by healthcare staff. The risk assessment assesses whether a prisoner is likely to abuse the trust given to them to hold their own mediations. This includes whether they will trade the drugs to other prisoners and the possibility that they may harm themselves by, for and example, an overdose.)

106. Although there is no evidence to show how the man obtained the medication, the possibility remains that he may have received them from another prisoner. As such, the Governor and Head of Healthcare may want to consider this matter further, together with the conclusions of the toxicology report.

ACCT training

107. During the investigation, the reception nurse told my investigator that they had not been trained in the ACCT process. Prison Service Order 2700 (Suicide Prevention and Self Harm Management) says:

> "… all staff in contact with prisoners need to be aware of and trained to ACCT foundation level. Therefore it is important that Healthcare Managers – through the Partnership Board – make every effort to ensure the local training strategy reflects this in respect of all healthcare staff (agency wherever possible and permanent employees, whether existing or new) and mental health in-reach teams."

108. It is of the utmost importance that all staff are aware of, and have a good understanding of, the ACCT process. Although I make no personal criticism of the nurse I am, however, disappointed to learn that they had not been provided with formal training and make the following recommendation.

The Governor and Healthcare Manager at Elmley must ensure that all healthcare staff receive at least foundation level training in ACCT.

Did staff consider appropriately the man's level of risk?

Return from court

109. Those working in prisons should be aware that a change in prisoners' circumstances, such as being convicted, can have an effect of their behaviour and possible subsequent actions. One of the officers working on the houseblock was asked by my investigator if he and other members of staff were aware that the man and his son had been convicted that day. He said: "Yes because when they came back it was what went round the house block like wild fires". The officer said the prisoners on the houseblock would have got the information from the news. He said that: "… when they came back it was a sort of million and one questions being shouted through the doors…" He said that as a consequence all of the prisoners and officers on the wing were aware of the conviction.

110. There is little doubt that staff both in reception and on the houseblock knew of the man's conviction, due to the high level of publicity it received and its reporting on the local television news. As a consequence a number of staff said that they took time to talk with him on his return from court. However, no-one recorded their contact with him. Prison Service Order 2700 says that reception staff must ensure they talk with prisoners who have experienced a change in their status such as conviction. The order says that staff should maintain a record of such contact, and I include this in a recommendation made in the record keeping section of this report.

The visit on 11 December

111. During a visit on 11 December, the man's friend said he told him that he had stopped taking his medication and was saving it up in order to take an overdose. He reported this information to staff on duty. However, the officers said that they were told that the man had stopped taking his medication because he only had eight or nine years to live. The officers said that they passed this information to staff on his houseblock. On his return to the houseblock, he was seen by another officer. He told the officer that he was fine and had no problems.

112. I am unable, after the event, to determine whose recollection of the conversation is correct. Not being present at the time, the investigation is reliant on what is told to my investigator. However, what is clear is that concerns were raised by the man's friend with members of staff. It is also known that consideration was given by staff to the information and

subsequent action was taken to ensure that the man was seen by an officer on his return to the wing. During this meeting, he reassured the officer with regard to his wellbeing.

113. Although I am satisfied that staff acted upon information passed to them it is unfortunate that neither the officers in the visits hall nor the officer on the houseblock reported their conversations and actions in the man's case history notes or in the wing observation book. Although the officer who spoke to him said he had no concerns, such a significant piece of information should have been recorded. (The case history note is the area of a prisoner's electronic prison record where any member of staff can record their interaction with a prisoner, including their behaviour, concerns and other issues.) I return to this issue in the section regarding record keeping.

The behaviour of the man in the days before his death

114. Staff have a responsibility to act when the behaviour or actions of an individual indicate that they may be at risk of harming themselves. In the days leading to his death, the man's behaviour appears to have changed. Unfortunately it appears that much of this change in presentation was only revealed to other prisoners. It is unfortunate that some of his negative behaviour at this time was not brought to the attention of staff, as staff are unable to act if they are unaware of the problem.

General entries record keeping

115. In addition to the recording of significant interactions by staff with the man, I also note that for the entire period of time that he spent at Elmley only one entry was made in his case history notes. My investigator was unable to establish any detail about the time that he spent in custody from written records. It is of regret that prisoners, such as him, who are less demanding of staff's time and attention, often go unnoticed and, as a consequence, less is recorded about them. This, in turn, leads to less information being available for staff if and when it is needed.

116. As I have already discussed, all staff have a responsibility to record relevant information on a prisoner either in their case history notes or in the wing observation book. It is evident that in the case of the man this was not happening. I am disappointed to note that I raised a similar concern into the death of a man at Elmley in April 2008. As such I repeat the recommendation that I made then.

The Governor should remind all staff of the importance of completing the case history of prisoners in P-NOMIS and observation books, noting their interactions with prisoners and other pertinent information.

CONCLUSION

117. On his reception into Elmley the man was assessed on several occasions by members of the mental health team and expressed no thoughts of harming himself. In the year leading to his death, including his trial, he was described as being optimistic with regard to his trial. However, it is apparent that he was shocked at being found guilty, as his son described him as being "distraught" at the verdict.

118. In the days following his conviction the man's behaviour changed, although this was particularly noticed by his son in the days leading to his death. He talked on a number of occasions with his sister with regard to the fear of receiving a significant sentence. This was compounded by his fear that, given what he believed to be his poor health, he would not live long enough to be released.

119. Although, the man's risk of harming himself seems to have risen after his conviction, I do not believe staff could have foreseen his actions. When staff did interact with him, he consistently denied any thoughts of harming himself. Although the failure to adequately record conversations with him is concerning, I do not think that the prison missed any clear warning signs that he would take his life.

RECOMMENDATIONS

1. The Head of Healthcare should adopt an additional screening tool/template at the prison to meet the needs of prisoners who have experienced a change in their circumstances, to ensure that all aspects of a mental health assessment are clearly reflected upon.

   Accepted

   A full health screening and mental health assessment is to be in place for any prisoner received to HMP Elmley who have a change in circumstances.

2. The Governor and Healthcare Manager should ensure that a local protocol is in place that provides clear advice about situations in which the Ambulance Service should be called.

   Accepted

   Current systems are being reviewed to ensure compliance with national policy. We are inviting the regional ambulance coordinator into the prison to discuss agreed protocols.

3. The Governor and Healthcare Manager at Elmley must ensure that all healthcare staff receive at least foundation level training in ACCT.

   Accepted

   All staff in healthcare to be trained to ACCT foundation level.

4. The Governor should remind all staff of the importance of completing the case history of prisoners in P-NOMIS and observation books, noting their interactions with prisoners and other pertinent information.

   Accepted

   Notice to staff to be completed.