



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

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

May 2012

This is the report of an investigation into the death of a man who was a prisoner at HMP Wakefield. He was 47 years old. On a day in December 2010, the man was found hanging in his cell during the early morning roll check at 4.55am, and was pronounced dead at 5.10am. I offer my condolences to the man's family and friends for their loss and apologise for the delay in publishing this report.

HMP Wakefield, the police and diplomatic services all made efforts to contact the man's mother in Trinidad for more than a month. On 21 January 2011, his mother was informed of her son's death by Wakefield's prison family liaison officer by telephone.

My colleague was appointed to carry out the investigation. A review of the man's healthcare was commissioned from Wakefield Primary Care Trust (PCT). I am grateful to the clinical reviewer for carrying out the review. I am also grateful to the Governor of HMP Wakefield and her staff for their co-operation and assistance during this investigation.

The man had spent over nine years at Wakefield, and was regarded as a quiet and mature prisoner. His behaviour appeared to change in the last six months of his life. Most staff were not aware of any particular change but his friends noticed his decline in mood. The investigation explored the possible reasons for this change, such as bullying and mental health concerns, and whether Wakefield acted reasonably with regard to him.

Concerns were raised about the man's mental health but he had no contact with the mental health team prior to his death. In this report, I consider how information is shared throughout Wakefield. I also highlight gaps in the personal officer scheme, and their impact on him.

Prisoners who have served several years in prison still make up a significant proportion of the self-inflicted deaths this office investigates, and staff should remain vigilant even when prisoners appear settled.

I make three recommendations in this report regarding referrals to the mental health team, information sharing and the personal officer scheme.

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.

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Prisons and Probation Ombudsman

May 2012

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SUMMARY

1. The man moved to the United Kingdom from Trinidad at the age of 17, and lived in the Bedford area. After committing a series of sexual offences, he was remanded into HMP Bedford on 24 September 1999. In 2000, he moved to HMP Belmarsh and was then transferred to HMP Wakefield after being sentenced to life imprisonment in 2001.
2. The man was described as a compliant and quiet prisoner who did not often come to the attention of staff. He had a small group of friends on the wing and was always polite to staff and other prisoners.
3. Refusing to engage with offending behaviour courses, the man appealed against his conviction. His appeals were turned down in 2000 and 2003. He did enquire about the sex offender treatment programme in October 2006, but had not started it before his death.
4. From April 2010, the man's behaviour seemed to change. He was the subject of numerous security reports regarding fights, drugs and he was identified as a possible victim of bullying.
5. The Parole Board wrote to the man on 18 October explaining that they would not recommend his release or transfer to open conditions. The reasons given were his due to his refusal to attend any offender behaviour programmes, and his level of risk being deemed too high.
6. Throughout November and December, the man told his friends on a number of occasions that other prisoners and prison officers were spreading rumours about him and talking about his offences. He said he felt threatened, and claimed he was being released imminently. Mental health support was offered to him shortly before his death, but he said that he could cope on his own.
7. The man was found at 4.55am by the night patrol staff conducting the morning roll check on a day in December. He was hanging from a ligature tied to the sink unit and bed on the back wall. Due to his condition, staff did not attempt cardio pulmonary resuscitation. The paramedics arrived and pronounced him dead at 5:10am.
8. The prison's family liaison officer made numerous attempts to trace the man's mother in Trinidad. She was eventually informed of her son's death on 21 January 2011.
9. This investigation considered a number of issues, but did not find evidence of specific oversights on the part of the prison. However, I am concerned by the fact that the man's deterioration does not appear to have been perceived by the staff caring for him.

THE INVESTIGATION PROCESS

10. My colleague opened the investigation at HMP Wakefield on 6 January 2011. (The delay in opening the investigation was caused by the severe weather conditions at the time of the man's death.) He met senior prison managers and took copies of the man's files. He also met a representative of the Independent Monitoring Board (IMB). Notices of the investigation were issued to staff and prisoners, inviting those who wished to provide information regarding the man's death to make themselves known to the investigator. A number of prisoners responded, and eight prisoners were interviewed.
11. The investigator and two colleagues returned to Wakefield on 2 and 3 March to interview staff and prisoners. The investigator sent a feedback letter to the Governor on 4 March to alert her to the initial findings of the investigation. The investigator and one colleague returned on 20 and 21 April to conduct further interviews.
12. Wakefield Primary Care Trust (PCT) was commissioned to conduct a review of the medical care that the man received in custody. The PCT asked a clinical reviewer to conduct this review.
13. The investigator wrote to HM Coroner West Yorkshire Eastern District to inform of the investigation. A copy of my report will be sent to him, to aid the inquest.
14. One of the office's family liaison officers made contact with the man's family and offered them the chance to contribute to the investigation. They instructed a solicitor in the UK, and the investigator has kept in touch with her to keep her informed of the progress of the investigation. The man's family were concerned about a letter that he sent to them which indicated that he felt threatened because of people talking about him.
15. The man's mother requested his personal belongings together with educational certificates and money that had been left in his account. She gave written consent for his body to be cremated and repatriated to her in Jamaica.
16. At the end of the draft report consultation period, the solicitor for the family sent a letter to the office requesting further prison documents and forwarded an email from the man's family. They expressed their continued concerns about the level of mental healthcare provided to him, and the allegations of bullying. The investigator contacted Wakefield and arranged for a number of prison documents to be sent to the family's solicitor. One of these was a letter from the man that had been in police possession, and had not been previously seen by the investigator.

HMP WAKEFIELD

17. HMP Wakefield is a high security prison for male prisoners serving four years or over, including prisoners serving life sentences. It is part of the high security estate, for prisoners who potentially pose the greatest risk to the public or state.

Sex Offender Treatment Programme

18. The sex offender treatment programme (SOTP) is an offending behaviour programme which aims to address behaviour which has elements of sexual offending. It is not mandatory, and all participants must be willing to participate in the programme. It is not suitable for anyone who denies their offence.

Security Information Report

19. Security information reports (SIRs) hold security information that has been collected on prisoners by staff. Any member of staff is encouraged to record any piece of information on a prisoner, no matter how small or insignificant it is. The information that has been received is evaluated on how reliable the source that has provided it is, and on the potential impact that it would have on the prison's security should it be true.
20. Prisoners can request to see the contents of SIRs, but the Prison Service can withhold sensitive information if it would jeopardise how the information was collected, or the security of the prison. The Ombudsman's office has full access to all SIRs.

Suicide and self harm monitoring

21. The Assessment, Care in Custody and Teamwork (ACCT) procedures aim to help and monitor prisoners at risk of harming themselves. The key aims of ACCT are to create a safe and caring environment, identify prisoners' individual needs, and provide individualised care and support before, during and after a period of crisis. Once an ACCT is closed a post closure review should take place within seven days to check how the prisoner is coping following the closure of the ACCT.

Roll check

22. The roll check is the physical count of the number of prisoners on each wing within a prison. Roll checks occur on a number of specified occasions during the day and night (at the start and end of the shifts), and staff sign that the roll is correct.

Anti-ligature knives

23. Anti-ligature knives are used to cut ligatures. All staff in closed and semi-open prisons that have contact with prisoners must be provided with and carry, when on duty, their own knife.

Emergency response codes

24. In a lot of prisons across the country, the codes used in emergency situations are 'red' and 'blue'. Blue indicates that a person has breathing/respiratory problems and red that the person is bleeding. The codes allow the medical staff to respond with appropriate equipment.

Critical debrief

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

Independent Monitoring Board

26. Every prison in England and Wales has an Independent Monitoring Board (IMB). The IMB are a body of people appointed to each prison that are independent volunteers they are required to produce an annual report highlighting good practice and flagging up areas of concern. In their latest report from 2009-10, the board commented that they felt suicide and self-harm monitoring procedures had improved by being discussed in the safer custody meetings. They also urged that the staffing issues in the healthcare unit should be addressed as soon as possible.

Her Majesty's Chief Inspector of Prisons

27. Her Majesty's Chief Inspector of Prisons undertook an announced inspection of Wakefield from 1-5 December 2008. The introduction to the report says:

“Wakefield was, in general, a safe prison and this was confirmed by prisoners. However, it was not clear that suicide and self-harm, or violence reduction, procedures were properly targeted at the specific risks presented or faced by Wakefield's particular population.”
28. The inspection also found that the mental health services were stretched, and were not involved in the safer custody meetings. Almost all prisoners interviewed said that they had a personal officer, although the inspection noted that further work was needed in this area to improve the system.

Previous deaths at Wakefield

29. There have been nine self-inflicted deaths at HMP Wakefield since I took responsibility for investigating deaths in 2004. The most recent death was in June 2008, and the deceased also took his life by hanging. However, the circumstances of the death were different, and none of the recommendations made are relevant to this investigation.

KEY EVENTS

30. The man was remanded into HMP Bedford on 24 September 1999. In 2000, he moved to HMP Belmarsh and was then transferred to HMP Wakefield after sentencing in 2001. He was given a life sentence with a minimum tariff of ten years.
31. Upon his arrival at Wakefield, the man was assessed as not suffering from any medical condition. A psychological assessment carried out in 2001 found him to be dependent, masochistic, depressive, anxiety and having dysthymia (a type of mild depression). He was referred to the healthcare department. In his 2001 sentence plan, it was noted that the man did not want to participate in the Sex Offender Treatment Program (SOTP) as he maintained his innocence and was appealing against his conviction. His appeal was dismissed in February 2003.
32. The man was described as quiet and compliant by the staff and prisoners that my investigators spoke to. He had a small, but close-knit, group of friends that he associated with, although he was said to get on with everyone. The staff on A wing that my investigators spoke to said that he would speak to them when he needed to, but would not do so unnecessarily. He was regarded as a prisoner who did not demand much from staff.
33. However, throughout the man's years at Wakefield there were a number of security information reports (SIRs) written regarding him. In 2003, he was mentioned in a SIR that suggested he, along with other prisoners, may have been bullied by a group of prisoners. In late 2004, there was reference to a conflict between himself and another prisoner, although it was noted that the man was not the instigator. In July 2005, a SIR was written after he was found with several lengths of black bin liner plaited together resembling a dog lead with a handle at one end. When questioned about it, he stated it was made to keep his trousers up. The item was removed by staff. A further SIR in December reported the smell of cannabis coming from his cell.
34. Another SIR was written in May 2006 regarding a letter written by the man to a prisoner at HMP Whitemoor (a former HMP Wakefield prisoner). He made reference to there being a lot of racist prisoners on the wing. He said that he was feeling very "low" at this time.
35. The progress report from the man's personal officer, written in June 2007, said that his behaviour on the wing was normally of a very good standard. He was compliant and maintained good personal and cell hygiene and did not give staff cause for concern. However, the report noted that he did not regularly interact with staff. When asked why, he said that he was being cautious. When asked if he would approach staff with a problem he said staff would be his first option. He said that when he felt stressed, he would cope by reading, listening to music and painting.
36. At the man's sentence planning meeting in September it was recorded that "there are no current self harm or threats to others". He received a letter from

the Parole Board in January 2008 which said that it had not recommended a transfer to open prison

37. A SIR dated 15 June 2009 said that the previous occupant of the man's cell had threatened to kill him. The man had recently moved into the cell and told staff that the floor was burnt around the bed. Staff believed that the other prisoner had burnt the floor to detach his bed with a view to barricading himself in the cell (the beds are screwed to the floor to prevent them being moved). Intelligence also indicated that the prisoner had threatened sex offenders in the past. The matter was referred to the safer custody department and wing management were advised of the threat to the man.
38. Another SIR from June included information from a different prisoner who told staff of friction between the man and himself which would probably end in a fight. This was also referred to the safer custody department and wing management. The man asked about the Thinking Skills Programme in November 2009, and was advised to put an application in to the relevant department.
39. An officer from the wing became the man's personal officer in January 2010. He recorded that he asked the man if he was ok, and should contact him if he had any problems. He made a further note in February where he recorded that the man said: "he was alright and had no problems at this time."
40. On 19 April, the man and a prisoner were seen fighting on the top landing in A wing. A prisoner told the investigator that he alerted staff to the conflict. Two officers intervened and both prisoners were locked in their cells. When the prisoner was asked about the fight, he said he had walked past the man who said "I don't like how you walked past me". He said the man lunged at him and they began to fight. (Later when the man undertook a course, he wrote about the fight he had with his fellow prisoner. He explained that the fight started because of the way the prisoner pushed past him.)
41. The man and his fellow prisoner were placed on report to be adjudicated. (An adjudication is an internal hearing into breaches of prison discipline.) Neither prisoner required medical treatment. A senior officer also believed the fight started because of the way the prisoner walked past the man, telling the investigator:

"[The prisoner] came up and walked between them quite bad mannerly and [the man] pulled him and said 'where's your manners?' and [the prisoner] being [the prisoner], one of these bully-type people, turned around and started fighting with [the man] and [the man] retaliated."
42. When my investigator spoke to one of the officers who had intervened, he said he did not know why the fight had started. Some of the prisoners that my investigator spoke to told him that the fight had started because the man had caught his fellow prisoner stealing from his cell. However, the man's friends from A wing suggested that the fight originated because the prisoner had pushed past the man.

43. The officer said that, once he and his colleague intervened, the fight ended and he was not aware of any significant continuing problems between the man and his fellow prisoner. The man's personal officer told the investigator his recollection of the fight:
- “We never actually got to the bottom of why it actually was but he did say, after it had happened, it was all over and it was all sorted. ... I did speak to him about it but he didn't want to elaborate on what it was actually about. He just said it was a fight, it was over and done with and that was it basically. So he didn't want any further action or any further, he had no further problems as far as I'm aware with that individual.”
44. The senior officer agreed that the conflict ended once the fight did: “As far as I was aware that was it done and dusted. They both got adjudicated and it was finished.” However, certain prisoners said that, following the fight, the fellow prisoner's friends (a group of Muslim prisoners) continued to intimidate and harass the man. The man's close friends on A wing denied that anyone was threatening or harassing him at any point prior to his death. They believed the problem between the man and his fellow prisoner to be over once the fight was stopped. The adjudication was initially opened on 21 April but was adjourned as the fellow prisoner wanted to obtain legal advice.
45. In April, the man began the thinking skills programme. This course can be undertaken by prisoners who deny their offence. A senior officer wrote that the man had an episode of depression and had been low in mood during the problem solving module. He had also said at this time that he would like to find out more about the sex offender treatment programme.
46. A SIR dated 26 April said that the man was buying 'hash' (marijuana) from an unknown prisoner and it was making him paranoid. Another SIR from April said that he had amorous feelings for a female officer. It noted that he had said that the feeling was reciprocated and she went to the kitchen when he was cooking in there. The investigator spoke to the female officer who said that she only had very limited contact with the man, although she knew who he was. She said that she was unaware of any feelings he may have had for her, and had not had any inappropriate interactions with him.
47. The investigator spoke to one of the man's friends. He said that the man had told him that a female officer was in love with him. His friend explained that the man had said that he had refused her advances, and was very worried about the repercussions of other people finding out about his rejection of her. The man's friend said to the investigator that, as he was a mature and sensible man, he assumed his friend was being truthful. However, the man's friend said that he had never seen his friend and the female officer together.
48. Another prisoner was told of this situation. He was a close friend of the man and told the investigator that the man had said he had a problem with an officer because he had rejected her advances. The prisoner said that the

man had told him that this officer responded to his rejection of her by spreading rumours about him around the prison. The prisoner said that he would have heard rumours such as these, but had never heard anything. He thought his friend was being paranoid but told him to put a complaint in, if he felt it necessary. The prisoner said that the man later told him that a governor had come to see him to apologise for the officer spreading rumours, but the prisoner was not told who this governor was. Another friend said that the man had also told him about a governor apologising to him for the rumours. His friend said that he had never heard anyone talking about the man in that manner. My investigator has seen no record of any governor speaking to the man about this issue, and has been unable to find out if this happened.

49. A further SIR from the end of April said that a prisoner's partner was bringing drugs into the prison during visits. This prisoner was giving the drugs as payment for people cooking his food. The SIR named the man as one of his main customers. The SIR recommended that his cell should be searched as the intelligence suggested that the drugs were kept in his cell. The investigator asked for cell search documentation and was provided with records of six cell searches of the man's cell from 2009 and 2010. However, these were all for routine reasons and nothing was found during any of them.
50. A SIR was written in May claiming that the man intended to kill one of two high profile sex offenders, to try to engineer a move away from Wakefield. The report said that there were numerous recent reports regarding the man threatening to kill a high profile offender when his parents die. It also said that there was intelligence that he had been trying to obtain a weapon as he was recently found in possession of a home made weapon during a target search. The SIR referred this matter to the wing manager, head of residence and asked the mental health team to see him. There is no record of the mental health team seeing the man at any point prior to his death.
51. His personal officer made an entry on 2 June in the man's file:

“[The man] has raised no concerns with me since my return to the wing after completing a period of nights. He said he is ok and he would see me if anything changes.”
52. The man was adjudicated on 9 July for his April fight with his fellow prisoner. The charge for fighting was proven and the man was punished by stoppage of earnings for 14 days, cellular confinement for 7 days and forfeiture of his privilege to use his private cash for 14 days. These punishments were suspended for three months. The records reveal that there were no concerns over his mental health at the time of his adjudication.
53. The man's personal officer went on sick leave at the start of October. He told my investigator that, at the time he left the prison, he had no concerns about him. The personal officer entries that he made in the man's record up until his sick leave reflect this.

54. The man received a letter from the Parole Board dated 18 October saying that he would not be released, or recommended for transfer to open conditions due to his level of risk being too high for release. It noted that he refused to undertake any offender behaviour work and continued to maintain his innocence.
55. A SIR dated 10 November concerned a letter written by the man to his probation officer. The letter claimed that staff had informed prisoners of his offences and the information had spread, putting his life at risk. He said he was now suffering from deep stress and emotional discomfort and had to endure name calling and threats of harm. The SIR referred to a former SIR where he told other prisoners that an officer went into his cell and told him that she was in love with him. The SIR highlighted previous concerns about his state of mental health. The SIR noted that there was no intelligence to suggest that members of staff had disclosed details of his offence to others. The SIR recorded that referrals were made to the wing manager, safer custody team and head of residence. It also suggested that staff consider wing move. My investigator has seen no record of a wing move being considered by staff.
56. The prisoners that the investigators spoke to gave varying accounts of the man's state of mind during the final months of his life. One, who worked with him in a prison workshop, said that he had seemed worried by the alleged harassment he received on A wing (following the fight with a fellow prisoner), and wished to move wings. Another prisoner agreed with this account.
57. The man's friends on A wing said there was no harassment of him on A wing. However, they recalled that in the final months of his life he became increasingly paranoid and concerned that prisoners and staff were talking about him. One friend explained that the man told him that he had heard prisoners on other wings talking about him at 2.00am one night, and became convinced people were talking about his offences. His friend said that he told the man this was not happening as he would have heard such shouts too. He said that he suggested to him that he may have started hearing things that were not really happening but the man denied this.
58. On 17 November, a SIR was submitted stating that the man was feeling down as all the prisoners know about his crime. The person who provided this information was unknown.
59. One of the man's friends said that his behaviour changed in the weeks leading up to his death. He said that the man stopped going to the gym and cooking in the kitchen. (Prisoners have the choice of collecting their meals from the canteen or cooking them in the wing kitchen.) He explained that the man became reluctant to leave his cell because of his fear of attack.
60. Another of the man's friends from A wing also told my investigators that he became very paranoid in the week leading to his death. He explained that the man told him that a new group of prisoners from Liverpool were talking about him and his offences. He said he told the man this was not happening. He

said that he also had to reassure the man when he said that an officer had brought a weapon into the prison to assault him with.

61. A friend of the man's on A wing told the investigators that on the Sunday before his death (12 December) he had gone to the man's cell. The man hid something as he entered, and then broke down in tears. He said that the man told him that he was angry and had had enough. The man told him that he had considered suicide, and his friend realised that the item he had hid was a belt. He tried to reassure the man, and then told his other friend and friend of the man's, of his concerns.
62. The man's friend said he went to see him and he was tearful. He told his friend he was worried about the type of thoughts he was having, and was considering committing suicide. His friend believed that the man was being sincere about his suicidal thoughts. The man's friend told the investigator that he told a member of staff that he was concerned about him. However, he said that he told the member of staff that he believed he and his friend could look after the man. The man's friend said that he asked the member of staff to refrain from informing the healthcare department. He said that, as the man already seemed paranoid, he did not want to exacerbate this by telling staff and bringing more attention onto him. The man's friend was unwilling to tell the investigator the name of the member of staff that he spoke to.
63. In the last week of the man's life, he told his two friends that he had been cleared of his convictions and was to be compensated for his imprisonment. One of his friends said that this claim was initially convincing, but he then realised that it could not be true. Both his friends said that, although they realised that his thoughts were confused, they supported him by not contradicting him.
64. On 11 December 2010, the man spoke with an officer and said that two prisoners were commenting on his crime and shouting at him for no reason. He mentioned that he and one of the prisoners commenting on his crime had fought six months ago (the fight in April) but he thought the incident was resolved. The man said that he wanted the safer custody department to talk to the prisoners concerned. (The officer was a safer custody officer.) The officer told my investigator that he spoke with the other prisoner who said he had never spoken with the man, did not know who he was and was not a bully.
65. One of the prisoners on A wing spoke to my investigator about an incident that occurred in the week prior to the man's death. The prisoner recalled that at about 5.15pm on the Monday of the week the man died (13 December), he heard staff calling the man to come to reception. (The prisoner believed it was to collect something he had ordered.) As the prisoner was passing the man's cell, he looked in to see if he was coming down. He said that the man was "clearly petrified" with eyes wide open saying "I won't come down." The prisoner said that he told staff that the man was too scared to come down.

66. A SIR submitted after the man's death by a member of staff from the education department included further information about his claims of being found innocent:

"On Wed 15.12.2010 at approx 2.30pm [a prisoner] came into class and said he had some good news about [the man] he was going home the prison had helped him out and he had been found not guilty. [Another prisoner] replied do not listen to him that is not right he hasn't been talking right for weeks saying he is getting out and that he had fallen in love on the out."

67. An officer and his colleague in the safer custody team went to speak to the prisoner involved in the fight with the man back in April, on 15 December. He told them he had not bullied or intimidated the man as he had no reason to do so. The safer prisons referral form was written up by the officer and passed to a senior officer. The safer custody officer told my investigator that he went back and visited him later that afternoon:

"I remember going back with [my colleague] and we had like a chat with him on the afternoon before he died and to be perfectly straight he said 'sound - it's sorted now, boss, its quiet now, I'm alright'."

68. The officer from the safer custody team was unable to recall why they had visited the man on that day. However, when the investigator spoke to his colleague she confirmed that they went to tell the man of the results of their meetings with the two prisoners that were commenting on his crime. She said that when they told the man what the other two prisoners had said, he told the officers that the prisoners' comments had been general comments, and were not directly aimed at him. She said that the man appeared to want to defuse his earlier allegation, and was clear that he did not want any further action taken:

"... when we went back to see [the man] he kind of almost tried to defuse it a little by saying 'oh, well it wasn't anything aimed at me, it was just general comments that I thought had upset other prisoners.'"

69. The officer described the man's body language as appropriate and said he maintained good eye contact with her colleague throughout the interview. She told the investigator that neither she nor her colleague had any concerns about him at the end of the interview.

70. A senior officer and officer also visited the man later on 15 December at about 6.00pm. The senior officer told my investigator that the man told him that he realised that his earlier concerns were in his head, and he now understood that the shouting was general conversations between prisoners and not aimed at him. The senior officer recorded that the man said that his emotions had been high lately but he felt more settled now:

"... he said he realises that it was himself being paranoid. People are shouting on the wing, this is what he's saying to me, he says they're

shouting on the wing and I'm feeling that they're shouting at me but I'm realising now they're not, they're shouting to each other about something totally different and because of the way I was feeling with my emotions being high I've been thinking it's me he says and I realise now that it's not, it's nothing to do with me."

71. The senior officer told the investigator that he offered support from the mental health services to the man but he said he was coming through it and had a friend who was very supportive. He said that he would talk to staff he trusted, such as a certain officer on A wing, about his feelings. The senior officer confirmed to the investigator that he emailed the mental health team to say that the man did not wish for their input. He said that he wrote in the email that, given the man's wishes and demeanour, he agreed that the mental health team did not need to become involved, but wing staff would continue to monitor his behaviour.
72. Following the man's death, the mental health team confirmed to my investigator that they held no documentation relating to the man, and had no record of any referrals being made to them regarding the man. (This does not include the email mentioned above, which the manager from the mental health team recalled.)
73. The senior officer said that he initially went to see the man that evening regarding another issue. The prison censors had read a letter sent by the man to his mother expressing concern about prisoners taunting him about his offences. The senior officer wanted to discuss the man's concerns with him. He recalled the conversation he had with the man to the investigator:
- "I said 'what about the letter, do you want me to send it to your mother or do you want me to give you it back?' And that was like a test to see which way he was going. He said 'no, no way do I want that letter sending, give me it back' he says 'because I'm past that now, I'm coming through it.'"
74. The senior officer said that he had absolutely no concerns about the man that evening, and did not consider that any further actions such as ACCT procedures were necessary. He recalled to my investigator: "He was quite cheerful and relaxed and he says 'yes, I realise now what's been going on and it's all been in my mind. My emotions have been going up and down.'" He said that when he found out that the man had apparently taken his life, he was shocked.
75. An officer undertook the morning roll count on the fourth floor landing (4s) on A wing. At approximately 4.55am, he reached the man's cell. (The man was not subject to any specific checks so he would not have been seen since the roll check the previous evening.) He looked through the cell observation flap and saw the man hanging from ligature between the sink unit and bed on the back wall. The ligature was tied to the window bars. The officer immediately ran down the stairs and called for assistance. A senior officer had just arrived on A wing and immediately ran up to cell A4-29, closely followed by the Night

Orderly Officer and a third officer. The senior officer opened the cell door and they entered the cell. They requested assistance from the healthcare department and asked for an ambulance.

76. The senior officer explained to my investigator that it became immediately apparent that there was nothing they could do to help the man. He described the man as cold and said rigor mortis had already set in. The third officer used his anti-ligature knife to cut the ligature above the knot and lowered the man to the floor. Healthcare staff attended. The paramedics arrived at 5.08 am and pronounced the man dead at 5.10am.

Liaison with the man's family

77. A family liaison officer (FLO) was appointed. She checked the man's prison records but there was no telephone number provided for his mother. However, the man had included a firm of solicitors in Bedford as his next of kin. When the FLO rang this number the receptionist said that she had never heard of the man or the name included as next of kin. Over the next few weeks the FLO contacted the Trinidad and Tobago embassy in London and Foreign and Commonwealth Office to try to get contact details for the man's mother. The chaplaincy department also contacted their colleagues in Trinidad and Tobago. Unfortunately none of the numbers or people found by these efforts was the correct one for the man's mother.
78. On 29 December, a Christmas card was received for the man from his mother in Trinidad. The FLO contacted the Trinidad and Tobago High Commission again on 4 January 2011 to try and trace his mother's telephone number but was not successful. On 21 January, she obtained a telephone number from one of his mother's friends in the UK and broke the news of her son's death to his mother over the telephone. The man's mother confirmed that she wanted him cremated and the ashes sent to her. The prison arranged for the man's ashes and possessions to be sent to his mother.

Support for prisoners

79. After the man's death ACCT reviews were completed for prisoners on A wing to ensure that those prisoners already vulnerable were not unduly affected by his death.
80. Of the prisoners the investigator spoke to, all but one prisoner said that the support the prison offered after the man's death was adequate, and they knew where to go for advice if they needed it.
81. However, one of the man's friends did not feel as supported. He told the investigator that the governor who told him of his friend's death did not look at him in the face.

Support for staff

82. The senior officer explained that, following the finding of the man, the care team were contacted and approached each member of staff involved to support them. A hot debrief was undertaken to give each member of staff a chance to review the events of the morning. He described the support the staff involved gave to each other:

“It was pleasing to see how everybody kind of helped everybody else through that week up until the end of the week. It was quite pleasing to see how everybody helped each other and we did, we got on with it as we had to.”

83. However, one officer did not feel well supported. He said that he did not feel that he was properly contacted by the care team and was not invited to a debrief after the man’s death which he would have liked to attend. It may be that because this officer had not been involved in the finding of the man that he was not thought of as requiring support.

ISSUES

Clinical care

84. A review of the man's clinical care was carried out by a clinical reviewer on behalf of Wakefield PCT. She describes the man's arrival at Wakefield:

"On transfer to HMP Wakefield it appears that [the man] settled in and no thoughts of suicide were noted."

85. The clinical reviewer writes in the conclusion of her review:

"No evidence in documents available to suggest [the man] was displaying suicidal thoughts or planning. There is nothing in his clinical notes to suggest [the man] was demonstrating suicidal intent at the time of his death."

86. The clinical reviewer makes three recommendations in her review regarding the monitoring of reviews and record keeping that I understand have already been accepted by the PCT. I therefore do not repeat them in this report.

The man's changed behaviour in the last six months of his life

Was the man being bullied?

87. The investigator had access to a number of sources that suggested the man was being bullied prior to his death. Some prisoners told my investigator that the man was harassed and taunted following his fight with a fellow prisoner. (However, it should be noted that other prisoners and staff denied this.) In addition, the man, in the last few weeks of his life, complained of being taunted by prisoners regarding offences.
88. It is not always possible, after someone's death, to determine whether they were the victim of bullying and the uncertainty increases when there are contradictory testimonies, as in the case of this man. Staff and the man's friends on A wing deny that anyone was targeting or harassing him. They said that it was inconceivable that it could have been happening without their knowledge of it.
89. The safe prisons meeting minutes from 2010 reveal that, subsequent to the man's death, concerns were raised by prisoners that insulting and intimidating behaviour was occurring on A wing. Prisoners said this behaviour happened across the establishment. However, even among the prisoners that the investigator spoke to who said that bullying occurred, none provided the investigator with any firm evidence of the alleged bullying. Their awareness of the bullying seemed to stem from rumours on the wing or from the man himself. In the last few days of the man's life he told staff that he realised some of the harassment that he had raised with staff had not really happened. Given this, it is possible that other prisoners heard of the alleged bullying from the man when he believed it to be real.

90. The man also believed that some staff members were targeting him, and said that one officer had brought a weapon into Wakefield to use to injure him. One of the man's friends told the investigator that he spoke to the man and explained that this was not really happening. None of the prisoners that the investigator spoke to suggested that any members of staff were targeting him in any way.
91. It would be remiss of me to rule out bullying entirely but, due to the lack of evidence, other than prisoner's testimonies that can be traced back to the man, I am unable to conclude whether or not he was the victim of bullying.

Was the man confused in the months leading up to his death?

92. In the months after April 2010, the man behaved out of character. For example, he believed prisoners were taunting him about offences, worried that an officer had brought a weapon into the prison to wound him, believed a female officer to be in love with him and told his friends that he was shortly to be released and compensated for his incarceration.
93. I have addressed the issue of staff and prisoners targeting the man above, and have found no clear evidence of either. My investigator spoke to the female officer concerned, and she said that she had never had any inappropriate contact with him. I have no reason to disbelieve her account. I have also noted that the prisoners who told my investigator about this never actually saw the man and the officer together themselves. Their source of information was solely the man.
94. It is clear that the man was not to be imminently released, and there was no intention to provide him with any form of compensation. The man's friends realised this, but did not raise their concerns with staff. The man told one of his friends shortly before his death that he did not like the way he was feeling and the thoughts he was having. He also admitted to a senior officer that he had been paranoid and knew now that the shouting was not directed towards him. He had become confused to a certain degree and, although I cannot say that all of his concerns were due to disorientated thoughts, it is certainly possible. This likelihood only makes the lack of communication with the mental health team discussed below more disappointing

The lack of referrals to the mental health team

95. Despite his behaviour, the man was not referred to or assessed by the mental health team between April 2010 and his death. My investigator spoke to the mental health team manager who explained that not every referral to the mental health team would necessarily result in the team contacting the prisoner. He explained that sometimes referrals are made regarding issues that fall outside of the mental health team's remit. In this instance, he explained that the team would contact the referrer to explain that, from the information on the referral, it did not appear to be a mental health issue. However, he said he would still expect the referral to be recorded in the

medical record, as an inappropriate referral is still a referral. No such referral is made in the man's medical record.

96. The mental health team manager said that, as in the case of this man, SIRs can include an instruction to refer the prisoner to the mental health team. However, he said that the security department typically did this over the telephone: "I've never had any written things from the security department." The mental health team manager said that, if referrals were taken over the telephone, the team should fill out a form to detail the information.
97. One SIR requested that the mental health team be informed of the man's behaviour, and another made reference to previous concerns about his mental health. However, my investigator was told that the mental health team has no documentation regarding the man, and therefore no record of any referrals on behalf of him. The discrepancy between what was written on the SIRs and what the mental health team were aware of is clearly concerning, particularly given the possibility that his mental health declined in the last six months of his life.
98. The system of referring concerns about prisoners to the mental health team is flawed. Allowing referrals to be made by telephone removes any effective audit trail and makes it harder for management to monitor the referrals. Although I am unable to say that mental health intervention could have saved this man's life, it is clear that they should have had much more information with which to decide how to manage the symptoms manifested by him. I am sure that the Governor and Head of Healthcare will want to consider whether the referrals system can be improved. To that end, I recommend:

The Governor and Head of Healthcare should review the means by which referrals to the mental health team are made and monitored.

Sharing of information

99. There was a lot of information about the man in the various SIRs written about him in the months leading up to his death. However, it is not clear if this information was adequately shared with the appropriate departments responsible for the care of the man. This report has already pointed out how information that should have been shared with the mental health team does not appear to have been passed on correctly. The security department must engage with other departments better regarding the information it possesses.
100. Throughout the investigation, there were a number of staff who spoke of the man as being a quiet prisoner who did not come to the attention of staff, however all the while a significant amount of paperwork built up regarding him in the background. The staff who dealt with him on a day to day basis did not appear to be in possession of the all the facts regarding him. This was despite the change in his presentation that his friends noticed, and despite the entries made in the wing observation book reflecting the information included on the SIRs.

101. A senior officer told the investigator:

“If somebody does raise an SIR they, or they should, enter it into the wing observation book anyway so everybody should be aware of any incidents that go on.”

102. The investigator has established that the wing observation book was generally updated with the information that prompted the SIRs. However, this merely prompts the question of why staff failed to perceive that the man’s behaviour had changed. The senior officer explained the SIR process to the investigator:

“When it gets sent up to security they’ll do whatever they do with it up there and then in the residential governor’s meeting in the morning it’ll be brought up. Now it all depends who’s attending that meeting. Only one SO from each wing attends that meeting and they should go back and feed back to whoever’s on the wing. Now if you’re not there for any reason you’ll miss that apart from looking in the observation book if it’s been put in there.”

103. Obviously, if staff do not attend this meeting they will not be able to disseminate the messages to their colleagues. Equally, attendance is futile without the effective sharing of information. I believe that the Governor should further consider the most effective means of sharing this vital information.

104. Even if the information was not effectively shared from the residential governors’ meetings, the information was available to staff in the observation book. Despite this, no proactive overall consideration of the man was undertaken until he complained of taunting in the days before his death. I am unable to explain why no-one acted earlier. My concern is that the entries in the observation book were not considered in the light of previous ones to reveal a man requiring assistance. Without someone taking leadership in this manner, it is unfortunately easy to see how the man’s gradual decline could be missed. The member of staff best placed to do this on an individual level should be the prisoner’s personal officer (called a case officer at Wakefield). The case officer scheme at Wakefield states that one of the duties of the case officer is:

“On commencement of duty check the observation book for entries relating to their prisoners, note this within their case document if appropriate.”

Case officer scheme

105. Wakefield’s case officer scheme states:

“The interaction between the Case Officer and offender is central. It is an essential element to dynamic security within the establishment. It establishes positive staff prisoner relationships.”

106. The man's case officer went on sick leave at the start of October. Up until that point, he saw nothing that concerned him regarding the man and noticed no change in his behaviour. He said that he could not recall the man ever coming to him with a problem.

107. The man's case officer worked on the ones landing and the man lived on the fours landing. He explained that he used to work on the fours landing and that was when he became the man's personal officer. When he moved landings, he remained his personal officer for continuity purposes. The intention was for prisoners not to repeatedly have their personal officers changed if they changed landings. He also told the investigator that, as he worked on the ones landing where the kitchen is, he had frequent opportunities to observe and speak to the man.

108. All case officers have a deputy case officer who should work different shifts. This allows them to cover the case officer when they are on leave. When the man's case officer went on sick leave, this other officer was supposed to take on responsibility for the prisoners he was personal officer for. However, the man's case officer told the investigator he was unsure who his deputy case officer was:

"I didn't know who was secondary to me and I didn't really have a notification, I mean I will have had, somebody had sent me an e-mail or something saying I was secondary to somebody else. I mean they've just actually re-done them all again because I know when I was on, like I say Monday I looked at my e-mails and I've actually got a new list now of other offenders that I've now got that have transferred in or they've just moved around."

109. The man's case officer went on to say that as he had been on sick leave for a long time, he was unsure to what extent anyone had covered the prisoners he was responsible for:

"You wouldn't go and say to them 'look, I'm off on leave, can you do this, can you do that'. It sort of doesn't work that way. I know it should do but the chances are that they might be off at the same time. Like I say I've been off the best part of six months, the chances are whoever's secondary has had a set of nights, had some leave, might have even been sick themselves. So it's not, the system's not infallible. But I don't know the best way to make it work."

110. Wakefield's case officer scheme does make provision for a replacement case officer to be used when someone is absent for a significant length of time:

"In the event of any long term absence to a Case Officer the Unit Manager is to consider the need for a replacement to cover all responsibilities until the individual returns."

111. The investigator was told the name of the deputy case officer for the man. One of the responsibilities of the case officer is to make entries regarding the prisoners they are responsible for. The case officer scheme says:

“Case Officers maintain an accurate chronological diary of contact with their prisoners using wing history sheets, identifying any significant events affecting them, on at least a weekly basis.”

112. However, following the case officer’s absence due to sick leave at the start of October, there are no further notes made in the man’s record made in the context of a personal officer. This suggests that no substantial interactions occurred.
113. It is not possible to say that effective use of the personal officer scheme would have prevented the man’s death, but it may have provided a chance for someone to notice the decline in his behaviour in the last few months of his life.

The Governor should ensure that staff are reminded of their responsibilities as case officers.

Should the man have been subject to suicide prevention measures?

114. The safer custody team visited the man shortly before his death in response to his concern that other prisoners were targeting him. Having conducted their investigation, they visited him again to inform him of their findings. During this visit, the man stated that he now realised that the other prisoners were not shouting at him specifically. When he was later seen by the SO on the wing, he went further and explained that his emotions had been heightened and this may have caused his confusion. The SO also spoke to him about a letter that the prison censors had picked up where he had written of other prisoners taunting him. The man spoke of his new understanding of the situation and requested that the letter be given back to him and not sent out. Due to this apparent lucidity, and the man’s desire to deal with his confusion himself, no ACCT procedures were begun. The SO offered mental health services to the man, but he declined.
115. I do not criticise the staff for their decision not to begin ACCT procedures or mandate mental health involvement, given the context they were making it in. However, I do think that no one seemed to know the man well, and recognise the changes in his behaviour. This reinforces the previous discussion of the need for the prison to adequately share the information it gathers on the prisoners it is responsible for.

Liaison with the man’s family

116. The man’s next of kin, his mother, lived in Trinidad. The prison was keen to break the news to her over the telephone, rather than to write to her. PSO 2710 (Follow-up to a death in custody) says that breaking the news over the

telephone is too impersonal and should only be used as a measure of last resort. However, I do not feel that the prison had any other option. They clearly worked hard to try to get contact details for the man's mother from a number of different sources. The prison also conducted the funeral in the prison chapel, which gave staff and prisoners the chance to pay their respects. I, therefore, am pleased to recognise the efforts made to make contact with the man's family and provide them with his ashes and property.

Support for staff and prisoners

117. The officer involved in the finding of the man spoke well of the care and support offered, and it is clear that the care team were available for the staff involved. However, a member of the wing staff did not feel as well supported. It may have been, that as he was not involved in the finding of the man, his managers did not realise that the death had still had an impact on him. I would remind the Governor that, particularly in places like Wakefield, staff work with prisoners for a long time. This means that a sudden death can have an impact on them, even if they are not involved in the discovery of the body. Support should be offered to all relevant staff.

The Governor should ensure that, following any future death in custody, support is offered to all staff responsible for the prisoner.

CONCLUSION

118. The last few months of the man's life contrasted with the previous years he had spent at Wakefield. While he had previously been a quiet and mature prisoner, he began to generate concerns and paperwork among various staff and departments. These concerns were varied in nature and, on the face of it, suggest that he was bullied and intimidated by a group of prisoners.
119. However, the investigation found different possibilities. The man was the source of the reports of his bullying and none of the prisoners the investigator spoke to could recall any actual incidents. This is particularly significant considering that he had other beliefs that are less credible such as the view that he was to be released and compensated. He also told staff and prisoners that he realised some of his thinking was confused.
120. It appears likely that the man was suffering from confused thoughts in the months leading up to his death. While it is unfortunate that his friends did not tell staff of the level of his distress, the prison has a responsibility to monitor the prisoners in their care. While some concerns were raised these went predominantly to the security department from where it does not appear they were efficiently disseminated back to the officers working with him. Successful information sharing is critical to the safe guarding of vulnerable prisoners, but it is also difficult to achieve given the numbers of staff and prisoners involved. I have made recommendations to help the prison try to address this task.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should review the means by which referrals to the mental health team are made and monitored.

The National Offender Management Service accepted this recommendation, and wrote:

“All referrals for assessment to the Mental Health Team (MHT) will either be made on the official referral form or in the form of an email/ task. Any information passed to the MHT will again be in written form. The MHT will record their response to any such referrals.”

2. The Governor should ensure that staff are reminded of their responsibilities as case officers.

The National Offender Management Service accepted this recommendation, and wrote:

“All staff performing the role of Personal Officer will be further trained to ensure that they are aware of their responsibilities. Additionally, guidance will be issued as a Notice to Staff confirming the duties of a Personal Officer.”

3. The Governor should ensure that, following any future death in custody, support is offered to all staff responsible for the prisoner.

The National Offender Management Service did not accept this recommendation, and wrote:

“The Care Team provided support for staff immediately following [the man’s] death and a critical incident debrief was also held. A local notice to staff was issued on the 16 December advising all staff that the assistance of the Care Team was available if they required support following the death of [the man].”