Investigation into the circumstances surrounding the death of a man at HMP Risley in July 2009

Report by the Prisons and Probation Ombudsman for England and Wales

September 2010

This is the report of an investigation into the death of a man, a prisoner at HMP Risley. He died on 13 July 2009 and was discovered in his cell with a ligature around his neck. He was 25 years old. I offer my sincere sympathy and condolences to the man's family and friends. I must also apologise for the significant delay in issuing this report and any additional distress that this has caused family and friends as well as the staff at Risley.

The investigation was initially carried out by my colleague. However, he was unable to continue with the investigation and it was completed by another colleague. An independent review of the man's medical care in custody was carried out by a clinical reviewer on behalf of the local Primary Care Trust. I am most grateful to him for his assistance. I would also like to thank the Governor and staff of Risley for their full and ready co-operation during the course of the investigation. I am especially obliged to the prison liaison officer for his help in liaising with the investigators.

The man had spent much of his adult life in prison. He was most recently sentenced to 15 months custody on 19 January 2009. Having spent the first few months of this sentence at HMP Altcourse, he transferred to Risley in April. He was not considered to be at risk of self-harm or suicide at all during this sentence apart from a period of 24 hours in May when the appropriate suicide prevention measures were taken. He had told an officer that his partner had suffered a miscarriage and he felt like killing himself. However, the following day he admitted he had fabricated this story to obtain a telephone call and denied any feelings of harming himself or committing suicide.

Staff and prisoners who spoke to my investigators all expressed their shock at the man's death, reflecting that he was a well-liked and cheerful prisoner. No one believed he presented a risk to himself. However, there were occasions, as above, when he gave false information to obtain additional telephone calls or presented with physical symptoms which staff suspected were not genuine, perhaps to get admitted to hospital.

I make four recommendations. Two of these relate to the emergency response. The first involves the clarification of when staff should enter a cell on their own and the second gives consideration to the use of emergency codes. Notwithstanding these points, staff attended his cell very quickly and made an appropriate judgement not to attempt resuscitation. The third recommendation is in relation to a mental health referral made for him which was not actioned and ensuring that communication throughout this process is robust. Lastly, there was no identifiable personal officer involved with him and I therefore make a recommendation in this regard.

However, my overarching impression of staff is that they invested time trying to help the man. This included assisting him with any physical health problems, as well as trying to alleviate some of the difficulties he experienced while being imprisoned away from his friends and family.

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

Jane Webb
Acting Prisons and Probation Ombudsman **September 2010**

CONTENTS

SUMMARY

Having been released from HMP Altcourse on licence in November 2008, the man was arrested on further charges on 12 January 2009 and returned to Altcourse. On reception, he was interviewed by an officer and a nurse, neither of whom assessed him to be at risk of self-harm or suicide. Indeed, during his time at Altcourse this remained the case.

He initially settled well in prison, gaining employment and completing victim empathy and alcohol awareness programmes. However, on 15 April, he lost his job as a cleaner for being disruptive. He was given notice of an adjudication hearing, due to the suspicion he was in possession of a mobile telephone and charger. The following day, he transferred to HMP Risley. It is unclear whether these events were related.

Again, when interviewed on arrival at the prison, the man denied any thoughts of self-harm or suicide and said he was happy to be at Risley. On 28 April and again on 24 May, he made claims to officers that his partner had suffered a miscarriage. On the second occasion, staff started suicide prevention measures since he also claimed he felt like killing himself as a result. These measures continued for 24 hours. However, in both instances staff discovered that he had made up the claims to obtain telephone calls to his partner. As is often the case, it seems he found it difficult being in prison and not having regular contact with her.

As a result of the second claim that his partner had a miscarriage, the man was referred to the mental health team. However, no action was taken on this referral and the team said they did not receive it. I make a recommendation in this regard to ensure the referral system is robust and staff are aware of the process.

The man complained of chest pains on 1, 21 and 28 June. Each time he was appropriately assessed by healthcare staff. On two occasions, he was taken to an outside hospital by ambulance for further tests to be carried out and discharged within a few hours. The diagnosis was muscular pain and was not thought to be serious. The clinical reviewer concludes that this chest pain was dealt with appropriately. For a number of reasons staff were concerned that the symptoms were not genuine and they therefore submitted information to security about their suspicions.

On 9 July, the man claimed that his son was in hospital and asked for a telephone call. Staff established that he did not have a son and again information was submitted to security that he was trying to obtain extra telephone calls.

Prisoners commented that the man got on well with others on the wing and had an established group of friends. Some said that he became increasingly upset about his relationship with his partner the week before he died. On 12 July, two prisoners noticed a cut on his arm. He said this had happened accidentally and, although the prisoners were unsure whether this was the case, they did not tell staff about the injury.

The following morning, the man was discovered hanging in his cell by staff. All those involved in the emergency response agreed that it was too late to save him and therefore no resuscitation was attempted. Staff reacted quickly to the emergency. However, I give consideration as to whether staff understand when they should enter the cell alone at night and the benefits of the introduction of a code system to be used in medical emergencies.

Throughout his time at Risley, the man does not seem to have been allocated a personal officer or, if he was, the required amount of contact was not recorded in his wing history sheet. (The personal officer scheme was introduced so that prisoners are given a named officer that they can approach for advice or to resolve complaints.) Such interactions may have been useful for a young man who was clearly finding it difficult being located away from his partner and family. I therefore make a recommendation in this regard.

Prison staff visited the man's mother to tell her of his death and a memorial service was held that morning. Staff and prisoners were also offered support. Overall, I am satisfied that he was looked after appropriately by both discipline and medical staff and I concur with the view of the clinical reviewer that his death could not have been prevented.

THE INVESTIGATION PROCESS

1. The investigation was opened on 23 July 2009, when the investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information related to the man's death to make themselves known to the investigator. No staff or prisoners came forward as a result.

2. The investigator was given access to the man's prison files, including the medical record. He later returned to Risley with another investigator on 5 to 7 October to interview staff and prisoners. The Independent Monitoring Board (IMB) and the Prison Officers' Association (POA) did not wish to raise any issues with the investigator. He was unable to complete the investigation and it was therefore passed to his colleague in February 2010.

3. An independent review of the man's clinical care in custody was carried out by a clinical reviewer on behalf of the local Primary Care Trust (PCT).

4. One of my family liaison officers telephoned the man's mother on 12 August to advise her of the investigation and invite her to raise any matters she wished to be addressed. She raised the following issues:

    - The support he received from the Probation Service when released at the end of 2008 on licence.
    - Concern that prison staff did not communicate with each other as she received calls requesting the same information.
    - When she was told the news of her son's death, she felt too many questions were asked. She also questioned the subsequent suggestion by the family liaison officer that she see a medium (a person who claims to be able to communicate with dead people).
    - She was keen to know more about how her son's medical issues were treated.
    - Whether there was any assessment of her son and his needs following his transfer to Risley.
    - His belongings were removed for a period and then returned with items missing.
    - She had heard that her son had called the Samaritans and wondered how rigorously this was explored. She believes he should have had his belt removed.
    - Was there any incident or trigger for his actions in taking his own life?

5. The family liaison officer also telephoned the man's partner on 7 September. She raised the following issues:

    - Was there evidence that he was bullied at HMP Altcourse?
    - What mental health assessments or treatment did he receive?
    - Had staff noted her warnings about not leaving him with a belt?
    - She questioned why she and the family were not immediately informed of notes left for them by him.

- She wanted to know details of how he killed himself.
- She had heard from the police that he had fresh cuts on his rectum and wanted to know more about these injuries.
- She was concerned what had happened to some of his property and money following his death.

5. I have endeavoured to answer these questions in my report and I hope that it helps the man's family, partner and friends to better understand what happened in the time leading to his death.

HMP RISLEY

6. HMP Risley is a male category C training prison. On arrival into prison, prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. Category C prisoners are defined as those who cannot be trusted in open prison conditions but who would not have the ability or resources to make a determined escape.

7. Risley has seven wings and a segregation unit with an operational capacity of 1,085. The prison offers a variety of work, vocational training courses and a comprehensive education programme. It has 24 hour healthcare provision which is provided by the local Primary Care Trust (PCT).

8. The prison was most recently inspected by HM Chief Inspector of Prisons on an announced visit in July 2007. In her report, she said:

> "Safety remained a concern, conditions in parts of the prison were poor and there was still too little for prisoners to do. More positively, there was some reasonable resettlement work in place … Staff-prisoner relations were generally poor and were not helped by a weak personal officer scheme and an ineffective incentives and earned privilege scheme."

9. An Independent Monitoring Board (IMB) is appointed to each prison by the Secretary of State for Justice. Its members are wholly independent of the National Offender Management Service (NOMS) and the prison's management team. Each IMB is required to produce an annual report to the Secretary of State, highlighting good practice and areas of concern.

10. Risley's latest IMB report covers the period 1 April 2008 to 31 March 2009. The Board considered that the standard of healthcare at the prison was very good. They were also satisfied with the safer custody strategies employed by the prison and felt confident that incidents of bullying were appropriately dealt with.

11. The National Offender Management Service is responsible for the management of prisons in England and Wales. Every three months it publishes an assessment of each prison's performance against 34 measures. Prisons can gain a rating of between one (serious concerns) and four (exceptional performance). Risley has scored threes (good performance) for the last two quarters, and twos (requiring development) for the previous two quarters.

12. The man's death was the sixth to have occurred at Risley since April 2004, when this office began investigating all deaths in prison custody in England and Wales. There has also been a death subsequent to that of his. One of these previous deaths was self-inflicted and one was due to injuries inflicted during an assault. The rest were due to natural causes.

13. Following a death in 2007, I recommended the introduction of codes to indicate the type of emergency to staff responding to a request for assistance. Whilst this has been introduced, I am concerned that there is a lack of clarity amongst staff regarding its use and I therefore make a further recommendation in this regard. There are few other similarities between the man's death and those which occurred previously at Risley.

KEY FINDINGS

HMP Altcourse, 2 April 2004 – 15 April 2009

14. The man was brought up by his mother. He was diagnosed as having obsessive compulsive disorder and attention deficit hyperactivity disorder at an early age. Between eight and 16 years old he attended a boarding school for children with behavioural problems and left with qualifications in mathematics, science, English and geography. He also obtained art 'O' Level and NVQ qualifications in bricklaying and catering.

15. After leaving college, the man worked for four years for a company preparing food. He also worked in the motor trade, at a garden centre and as a refuse collector for short periods.

16. The man was sentenced to four years imprisonment at Crown Court on 2 April 2004 and taken to HMP Altcourse. This was his first substantial prison sentence, although he had been in prison before.

17. He initially had some difficulties settling in Altcourse, reflected in the five adjudications which were proved against him in 2004. (An adjudication is an internal hearing into breaches of prison discipline by prisoners). However, his behaviour then improved. He worked as a cleaner and under the Incentives and Privileges (IP) scheme attained level four status. (IP rewards and encourages prisoners' good behaviour and has four levels – reintegration, basic, standard and enhanced. Enhanced is the highest prisoners can achieve.) He was released on licence in July 2006. This meant that that he was under the supervision of the Probation Service and had to comply with licence conditions, one of which was not to re-offend.

18. Four months after his release, the man committed further offences. Since he had breached a condition of his licence, he was recalled to prison. He was taken to Altcourse and, in November, was sentenced to a further three and a half years imprisonment for these offences.

19. He again appeared to settle in Altcourse and became an IP4 (enhanced) prisoner. In September 2007, he fractured his jaw. He said this had happened by accident when he fell into the sink in his cell. He was taken to outside hospital where he had an operation and received follow-up treatment at the prison. In January 2008, he completed the Impact on Victims programme. However, in the months afterwards, his behaviour became increasingly erratic and he was abusive towards staff on a number of occasions. As a result, he lost his job as a cleaner and was downgraded to IP3.

20. At the beginning of May 2008, he told officers that he felt under threat from other prisoners on his wing. However, he did not provide any names and did not want any protection. He was advised to speak to officers if the situation

got worse. Officers had not noticed any hostility towards him but were asked to remain vigilant.

21. The man moved to another wing at his own request in mid-May and appeared to settle much better. He completed the Anger Management programme and gained employment in the servery and later as a cleaner. Officers remarked in his personal file that his behaviour was “great” and “perfect” and he was again made an IP4 prisoner.

22. Having had stomach pain for about a week, he was admitted to hospital on 24 July with possible liver failure. The fluid was drained from his stomach and he discharged himself the same day, remaining on crutches for a further two weeks.

23. His behaviour began to deteriorate as he came close to his potential release date, which was scheduled for 10 November. He became abusive and aggressive towards staff and other prisoners. He was due to be released on an End of Custody licence. (This was a temporary special dispensation for prisoners to be released up to 18 days early to ease overcrowding in prisons.) However, it was a mistake and he was found to be ineligible for release although the reason is not documented.

24. The man became angry at the decision and threw his television off the landing. As a result he was taken to the segregation unit for eight days to ensure his safety and that of other prisoners. (The purpose of segregation is to maintain safety, order and discipline. A segregation unit provides temporary accommodation for prisoners who have become violent or disruptive, committed offences against prison rules or require protection if they are under threat from other prisoners.) He also had an adjudication proved against him for endangering the health and safety of himself and others by throwing his television.

25. On 26 November, he was released from Altcourse, subject to licence conditions, including the supervision of the Probation Service. He was told to report to the Probation Office at 2.00pm that day as part of his licence conditions. He did so and met his probation officer. He attended five further weekly appointments with his probation officer throughout December and January. The last one took place on 8 January 2009.

26. During this time, the man’s probation officer completed offence-focussed work with him and started to prepare him for the Think First group (an accredited programme which focuses on problem solving) that he was due to start within two weeks. He said that the man did not ask for help with any particular issues and he appeared to be settling well following his release from prison.

27. The man was arrested on 12 January for committing further offences and was kept in police custody. By re-offending, he had broken the conditions of his licence. A report detailing the circumstances of his recall to prison was prepared by the probation officer and sanctioned by the Parole Board. Two days later, the man appeared at Magistrates Court in relation to the new

charges and was remanded to Altcourse the same day. The prison escort record (PER) identified no risk of harm to himself or others. (The PER is a form that accompanies staff on all prisoner escorts. It provides a chronological record of the escort and also serves as a communication tool about risks a prisoner poses on escort or transfer.)

28. An officer interviewed the man when he arrived at the prison. In response to routine questions, he said he had no thoughts or history of harming himself or attempting suicide. He was offered an appointment with the healthcare department, a prison routine established as research has shown that recalled prisoners can be more vulnerable than others, but he refused this. He also had a routine interview with a Carer and denied feeling anxious or having any concerns about being at Altcourse. (Carers are selected prisoners trained to provide confidential emotional support to fellow prisoners. Every new prisoner at Altcourse sees a Carer on their first day in prison and, if required, they have a follow up the following day with the same Carer.) This was not deemed necessary in his case.

29. A Cell Sharing Risk Assessment (CSRA) was also completed, which assessed the man as low risk and therefore suitable to share a cell. No risk to himself or others was identified. (The CSRA assesses the risk of harm a prisoner presents to others if they are required to share a cell.)

30. On 19 January, the man went to Crown Court where he was sentenced to 15 months imprisonment. He returned to Altcourse.

31. The offender management unit completed a risk assessment with the man two weeks later during which he said he had no history or current thoughts of self-harm or suicide. On 6 February, an officer introduced himself as the man's personal officer. The man told him that he had no concerns.

32. Around the end of February and beginning of March, there are several references in the wing history file to the man being upset because he said his father was in a coma in hospital. He said he felt frustrated as he was in prison and therefore could not see his father or help him. He was offered support from a chaplain or Carer but declined. He was given emergency credit for the telephone.

33. The man was granted IP4 status on 17 March as he had been working consistently well as a cleaner and was well behaved. He had also recently completed victim empathy and alcohol awareness programmes.

34. Just under a month later, on 15 April, the man lost his cleaning job for being disruptive. He was also given notice that he would have to attend an adjudication hearing for allegedly being in possession of a mobile telephone and charger which he had refused to give to staff. This adjudication did not take place.

HMP Risley, 16 April – 11 July

35. The man transferred to HMP Risley the following day. My investigator was unable to establish why he was transferred. The allocations department at Risley told her in May 2010 that they had only basic information remaining on their system. From this, they believed that he had been part of a regular transfer, as prisoners often move from Altcourse to Risley following sentence if they have a significant amount of time to serve. However, he told the reception officer at Risley that he had been transferred from Altcourse due to being caught with a mobile telephone. Altcourse were unable to confirm or deny this as the records were no longer available.

36. The PER which accompanied him to Risley identified no risk of harm to himself or others. An induction officer interviewed him when he arrived and he was given the opportunity to make a telephone call. He said he had no problems or any feelings of wanting to harm himself and had no issue with being in Risley. The officer had no concerns regarding where he should be located and, on a tick box form, described him as "quiet, indifferent and calm". He was given a single cell on the induction wing.

37. A nurse completed a healthscreen of the man later that day. He denied any current thoughts or history of self-harm or suicide or previous mental health issues. He commented that he was "happy to be at Risley". The nurse concluded that he was "fit and well".

38. The following day, the chaplain visited the man in his cell. It is the chaplaincy's duty to speak to all new prisoners within 24 hours of their arrival at the prison. The chaplain asked him whether he had any history of self-harm or suicide, recent bereavements or whether he knew anyone who was seriously ill in hospital. He replied "no" to all of these questions and told the chaplain that he had family support, naming his mother as his next of kin. The chaplain also gave him details of what the chaplaincy could offer him.

39. The chaplain told the investigator he did not consider the man to be at risk of suicide or harming himself. The chaplaincy team at Risley also has a commitment to visit everybody subject to Assessment, Care in Custody and Teamwork (ACCT) procedures. (ACCT is the suicide prevention system used by prisons to identify and support prisoners who are thought to be at risk of self-harm and/or suicide.) He is an experienced ACCT assessor and manager and said if he had detected any "slightest hint of risk", he would have opened an ACCT.

40. The education department completed an assessment with the man on 22 April to identify his sentence planning targets. He said he would be keen to work towards the targets set involving literacy, numeracy and bricklaying.

41. On 28 April, the man told a Senior Officer (SO) that he had spoken to a wing officer two days previously about his girlfriend having a miscarriage recently and he wanted to telephone her. The SO tried to verify this information with wing staff, including telephoning an off-duty officer at home. No one

remembered having such a conversation with him, nor was it recorded in his wing history file or the wing observation book.

42. The SO contacted the chaplain, who telephoned the man's mother. She said he had made a similar claim while at Altcourse and it was not true. The chaplain passed this information to the SO who, in turn, asked the man to come and speak to them both in the wing office. The chaplain asked the man for his partner's details and those of the hospital. (This is in line with protocol at Risley which states that bad news, such as a bereavement, must be confirmed with an outside authority.) The man said he would return with the information in ten minutes, but did not do so.

43. The chaplain told my investigators that he believed the man had been trying to obtain an extra telephone call to his partner. He completed a Security Information Report (SIR) on the basis of which the security department authorised the monitoring of his telephone calls. (SIRs hold security information on prisoners. Any member of staff can record information on a prisoner, no matter how small or insignificant it seems. The intelligence is evaluated according to the reliability of the source and the potential impact on the prison's security.) The chaplain remained of the view that the man did not present a risk of self-harm or suicide. The following day, he moved from D to G wing as part of a normal allocation as he had now finished his induction period.

44. On 24 May at around 9.00am, the man told an officer that his partner had recently had a miscarriage. The officer allowed him a telephone call to his partner. After this he told the officer that he "wishes he was dead" and "feels like hanging himself". The officer therefore completed a Concern and Keep Safe form. (This form can be opened by any member of staff and is the first step in the ACCT monitoring process.)

45. A second officer then completed an ACCT assessment interview with the man which examined his feelings, mental state and intentions in more detail. The officer noted that he felt low and depressed and, although he had no plans to commit suicide, he felt serious about doing so. They discussed various coping mechanisms and the impact his actions would have on others.

46. A second SO then completed the Immediate Action plan and assessed that the man should remain in a single cell and be referred to the community psychiatric nurse. The SO ensured the man was aware that he could have access to Listeners and telephone calls to his relatives. (Listeners, much like Carers in a private prison, are selected prisoners trained by Samaritans to provide confidential emotional support to fellow prisoners in distress.) The SO decided that staff should have "meaningful conversations" (supportive interactions when the member of staff talks to the prisoner) with the man three times each day, once every night and he was to be checked hourly. The SO also noted in the care plan that the man's partner should be contacted by his personal officer and pin credit (for the prisoners' telephone system) should immediately be arranged.

47. Soon after completing this assessment, the second SO reviewed the man's file and realised that he had also made a claim one month earlier that his partner had miscarried. The SO therefore rang the man's mother and asked if she had heard anything in this regard. She was unaware of any information regarding a miscarriage and believed her son was lying. The SO therefore asked the man to come to the wing office and asked him for further details. The man gave inconsistent versions of what had happened. The SO again telephoned his mother and allowed him to speak to her. However, the man claimed she was a liar and also called the SO a liar, alleging he had not called his mother.

48. The second SO said he found the man's outright denial that he had called his mother bizarre and was unsure as to whether he had mental health problems. He therefore referred him to the community psychiatric nurse (CPN) at 6.45pm. Since it was a Sunday, staffing levels were at a minimum. The SO therefore telephoned the mental health team and left a message on their voicemail referring the man. The SO said it was his understanding that normally such a message would be picked up and acknowledged with a telephone call by the mental health team the following day. As a result of his suspicions that the man was attempting to obtain additional free telephone calls, he also completed a SIR.

49. The investigators spoke to the mental health team manager regarding this referral. She told my investigators that the team had not received the referral. The usual referral method is to complete a pro forma and hand deliver it to the mental health inbox in healthcare. She said all staff were aware of this and it avoided any unnecessary delays in referrals. The referrals are then entered onto the electronic system. The prisoner is sent a letter and placed on a waiting list, or seen immediately depending on the risk they present.

50. The following day at 9.40am, the man's first ACCT review was led by the second SO with a third officer and the man also present. He admitted that he had fabricated the information about his partner's miscarriage in order to obtain telephone calls. The SO told him that he would still need to be assessed by the CPN and he agreed to this. The man apologised for wasting staff time and said he would not do this again. The ACCT was closed and a post-closure review set for 2 June.

51. In an email to my investigator, the safer custody department said that the post-closure review was carried out as scheduled. However, there is no information recorded in the ACCT documentation to indicate that this was the case and I am therefore concerned that it may not have happened. I note that the clinical reviewer is of the opinion that it did not take place. (This brief period when the man was subject to ACCT procedures was the only occasion when he was assessed to be at risk of suicide during his time in prison.)

52. On 29 May, the man moved to Birchwood (B) wing at his own request, to be nearer his friend from home. Although located on different floors, his friend was often in another friend's cell, which was next to the man's. He therefore spoke to him frequently about everyday things such as football. His friend told

the investigator that he never had any concerns about the man harming himself and said that if he had been worried, he would have told a wing officer. He considered that they are all approachable. He said that the man often came to talk to him and his friends when he found it difficult to cope with being unable to see his partner. The man's friend understood this to be the man's first relationship while he was in prison.

53. A prisoner occupied the cell opposite the man on B wing. He became friends with him soon after he was moved to the wing and they talked every day, often spending time in each other's cell, collecting their meals together and shouting through their doors to have a conversation after they were locked up. He told my investigators that the man was "stressed out" and spent a lot of time on the telephone to his partner. He thought he found it difficult being unable to see her and find out what she was doing. The man worried about her every day. However, the prisoner did not think that he had shared these feelings with staff.

54. Staff and prisoners said that the man got on well with the other prisoners. Another prisoner on B wing said that the man was always happy and smiling. The officer who worked on B wing said the man was cheerful and quiet and gave him no cause for concern.

55. In the evening of 1 June, the man complained of chest pains to an Officer Support Grade (OSG). The OSG asked a nurse to visit and assess him. He was prescribed paracetomol and brufen (both painkillers) and magnesium trisilicate (used to treat excess stomach acid). The man was advised that, if his pain persisted, he should press his cell bell. (A bell located in each cell to be used by prisoners in the event of emergency or if they require a member of staff's attention).

56. An hour later, the man again told the OSG his chest hurt. Healthcare staff attended and attached an electrocardiogram (ECG) to measure the rhythm of his heart. On the basis of the test and his complaint of shortness of breath, he was taken to hospital by ambulance. As is routine, he was accompanied by two officers and an escort chain was used to attach him to one of these officers.

57. However, at the hospital, officers became suspicious of a member of the public who walked past the man's room three times. Therefore, when he asked to go to the toilet the officers asked him to use the commode in the room. They were suspicious that he may have wanted to retrieve a package left in the toilet, which could have contained drugs. He refused this request and discharged himself at 3.15am, saying that he no longer wanted to see a doctor. He returned to Risley and the officers recorded their concerns in a SIR. He was seen by the prison doctor in surgery that morning who believed the chest pain to be muscular and gave advice and prescribed painkillers.

58. The following day, the man asked a governor to telephone his partner who he said was worried as the hospital had contacted her the night before when he

had been admitted. The governor contacted his partner who was not aware that he had been admitted to hospital the previous night.

59. On 5 June, a Principal Officer (PO) from the safer custody department received a telephone call from the Samaritans to say that the man had called them at 8.30pm the night before. He had told the Samaritans how "low and depressed" he was due to his wife's miscarriage. The PO therefore telephoned wing staff who told him that the man had lied about the miscarriage.

60. The PO told my investigator that this information had been given to him by the Samaritans co-ordinator, who trains Listeners in Risley. He said he assumed that they had either taken the telephone call from the man themselves, in their capacity as a community Samaritan, or had the information passed to them by another colleague. Since the Samaritans service is supposed to be completely confidential, my investigator asked how such information could be disclosed. The PO said he was not aware of any policy allowing them to do so but did not question this at the time, as the information was not new to prison staff.

61. Since the man had not been issued with the Samaritans telephone (a mobile used solely for calling the Samaritans) at any time on 4 June, the PO was concerned that he may have had access to his own mobile, which is against prison rules. When asked by officers, the man denied calling the Samaritans.

62. The PO submitted an SIR and as a consequence the security department authorised that the man's mail and telephone calls should be monitored between 12 June and 7 July. His letters were routinely monitored from this point onwards but there is no information about monitoring his telephone calls. Despite several requests to the prison, my investigator was unable to obtain any information about how frequently this occurred.

63. The man again complained of chest pains during the evening of 21 June. A nurse assessed him twice and used an ECG to monitor his heart. A record of which was sent to the local hospital for analysis and the result was normal. The nurse therefore asked the doctor to review him the following morning. A prison doctor assessed him on 22 June during morning surgery and gave him further advice and reassurance. The doctor still thought that the pain was muscular.

64. A week later, during the evening of 28 June, the man complained of chest pains to a second OSG. The OSG immediately contacted healthcare and a second nurse attended. The nurse assessed him, prescribed painkillers and advised him to ring his cell bell again if the pain got worse.

65. The man rang his cell bell half an hour later and the second nurse returned, having been contacted by the second OSG. The nurse carried out some tests, including an ECG and contacted the hospital with the results. Having reviewed them, the hospital told the prison to keep monitoring him at regular intervals.

66. The second OSG continued to observe the man and around midnight found him on the floor in his cell complaining of chest pains. He immediately contacted the healthcare department and the night orderly officer, a third SO, who went straight to his cell. (The night orderly officer is in charge of the prison and, as well as making regular patrols of the prison, must respond to any emergencies). The SO called an ambulance and the man was taken to hospital. The second nurse told the clinical reviewer that on this and other occasions when he assessed him, he did not believe he had any mental health issues.

67. All the tests at the hospital revealed results within the normal limits and the man returned to the prison at 3.00am the following morning. He was advised that any pain was muscular and should resolve itself within two weeks with the prescribed anti-inflammatories (ibuprofen). Later that morning, he told officers he was experiencing some lower rib pain and was given a painkiller by a nurse.

68. Officers who had taken the man to the hospital completed an SIR as they questioned whether his symptoms had been genuine. (This was in light of the previous SIR submitted when he went to hospital around a week earlier.) In addition, although he had appeared to be unconscious, he still had certain reflexes, for example when they moved him he put his hand out. It was recommended that, in future, an alternative hospital should be considered and he should be escorted by three officers and placed in two sets of handcuffs.

69. On 9 July, the man asked an officer if he could make a telephone call to his son who was in hospital. This was authorised by the wing SO but, when the officer allowed him to make the call, he did not mention his son. The officer therefore checked the wing file where he saw the record of the man's previous attempts to gain telephone calls. The officer then telephoned the man's mother, father and partner who confirmed that he had no children.

70. The officer said the man had looked worried prior to making the telephone call and he therefore asked his partner if he was having any difficulties she knew of. She said that he found it difficult being in prison, not knowing what she was doing all the time. She told the officer that he also told lies in Altcourse in order to get telephone calls. The officer therefore spoke to him who admitted that he had made up the story and apologised for this. On the basis of this, information was again submitted to the security department who authorised the reading and monitoring of mail and telephone calls until 6 August.

12 July

71. On 12 July at 10.32am, the man made a telephone call to his partner, and asked if they should end the relationship. He said he had made a cut on his arm the previous night and felt suicidal. This and other telephone calls he made later that day were not listened to until after his death by a third OSG, who recorded a brief summary of each call. Whilst my investigator had access to this summary document it was not possible for her to obtain a copy

of the transcript of the telephone calls as they had been erased from the system.

72. The prisoner who occupied the opposite cell said that the man seemed upset following this telephone call and asked him to make a telephone call for him to his partner, despite this being against prison rules. Around 20 minutes later, the prisoner made the call as a favour for a friend. He asked the man's partner if she was happy in her relationship with him which she confirmed she was. The prisoner told the man this.

73. In the next half an hour, the man made another two telephone calls to his partner during which he again mentioned he was feeling suicidal but that he was trying to calm down. He then ran out of credit and said he would see her on Wednesday.

74. The man's friend said that for the week before he died he had seemed particularly stressed about issues with his partner. On 12 July at around 4.30pm, the friend noticed that the man had a cut on his arm which he said had happened when he was making his bed. He was unsure whether to believe this, but said the man was joking as normal with him and his friends. He also noticed the cut and gave him a plaster to cover it.

75. The same afternoon, the second prisoner said that the man had come over to his cell and asked for some paper. This was unusual as he had never been in the prisoner's cell before. However, the prisoner said he seemed cheerful. He did not know of any issues the man had with other prisoners and was shocked when he found out he had died. Later that day, the prisoner helped the man write his partner a letter in which he asked her to come and see him the following Wednesday. He said he was finding it difficult to cope without her in prison. This letter was found in the outgoing post box after the man had died and a copy was provided to the investigator.

76. That day, the man made an application to see the dentist as he had toothache. He also made an application to transfer to HMP Stafford so that he could be closer to his family and it would be easier for them to visit. He placed both applications in the wing box but, since it was the weekend, it was not emptied until two days later.

77. The man collected his evening meal at 4.45pm and was locked in his cell at 5.00pm. The man's friend saw him when he collected his meal from the servery and said he seemed the same as usual. He said he had no concerns that the man was a risk to himself, otherwise he would have spoken to officers. He did not believe the man was having any problems with other prisoners and said he had a good group of friends on the wing.

78. The first prisoner told my investigators that later on that evening the man shouted to him from his cell that he felt "stressed out". He asked what was wrong but he did not reply. The prisoner said he was very shocked the following morning when he was told he had taken his life. He said if he had had any idea he was considering harming himself, he would have told staff.

79. The second OSG began work three hours later. His first job was to check every prisoner, including the man, and get a response from them. He then signed the log book to indicate that everything was in order and the officer on the day shift went off duty. He remembered hearing the man joking with the prisoner in the cell opposite him around this time.

80. The OSG was then locked on the wing on his own. He was carrying a radio and a sealed pouch containing a cut-down tool and a cell key to be used in the event of an emergency. (Cut down tools are used to cut ligatures. All staff in closed and semi-open prisons who have contact with prisoners are issued with and must carry their own tool.) The OSG has to patrol the wing every hour and push the pegging points on his rounds to prove he had done so. (Pegging is when an electronic scanner is used to provide an auditable register of the patrol.) He received a visit from the orderly officer three times during his shift, as is the agreed protocol.

13 July

81. The second OSG said that, unless a prisoner was subject to ACCT procedures or rang their cell bell during the night, he would have no reason to check on them between the start and the end of his shift. At 5.55am he started checking each cell on the wing by opening the observation flap, switching on the light and getting a response from each prisoner. Ten minutes later, he got to the man's cell and opened the flap. The OSG initially thought he was standing with his back to him so he kicked the door to get his attention and spoke to him.

82. However, the officer then realised that the man was hanging from the light fitting. He immediately radioed the control room and asked Oscar One (the third SO) and Oscar Two (a fourth officer) and the nurse to report to B wing as soon as possible. (Oscar One and Oscar Two are the radios assigned to staff responsible for responding to emergencies.) The OSG said he was asked for further details of the nature of the emergency over the radio and he said that it was a hanging.

83. At the time, the third SO was unlocking the main gate and had therefore taken his radio off momentarily, as was the normal procedure. The fourth officer was standing nearby and heard the call for immediate assistance on B wing over his radio. The officer shouted to the SO that there had been a hanging. Another officer and a fourth OSG, who was standing next to him, immediately started running to the man's cell. The SO asked another officer to collect the nurse from the healthcare centre (who would have been locked in there) and meet them at the cell. The OSG said the SO told him not to enter the cell on his own and he would be there within two minutes.

84. The duty nurse had to respond to any medical request for assistance, emergencies or otherwise. When she heard the radio call for assistance she began packing her emergency bag. She then heard that it was a hanging and radioed control to ask them to request an ambulance immediately.

85. Around a minute after the initial call for assistance, the fourth officer arrived at the cell and shouted to the man through the observation flap. He could see that the man had his back to the door and had tied his belt round his neck and to the light fitting. He said the man did not look as though he was actually hanging or suspended, more that he had bent his legs and was "slumped down".

86. Having received no response from the man, the fourth officer unlocked the door and was about to go into the cell when the fourth OSG and third SO arrived around 30 seconds after him. They all went into the cell and immediately judged that rigor mortis had begun, with some pooling of the blood in the bottom of his legs. The officer cut the ligature while the other officers supported him and lowered him to the floor. They were in agreement not to start resuscitation since he was cold to the touch, he was rigid and his arms and legs did not straighten when they laid him on the floor. The SO removed the belt from the man's neck.

87. By this stage, the nurse had arrived from the healthcare centre. She also agreed with the officers' assessment that the man had died and there was no purpose in starting resuscitation. She said it was obvious to her that he had been dead for a number of hours. The OSG was asked to leave the cell by the SO as he believed he was in shock. The OSG sat down nearby and the nurse checked on his well-being.

88. The paramedics arrived at the man's cell at 6.19am. Their opinion was also that he had died. They attached their defibrillator to him as is protocol to confirm that there was no cause to treat him and it confirmed "life extinct". (A defibrillator is a portable electronic device which measures electrical activity in the body and advises on the action to be taken.)

89. The man had left a letter in his cell which asked his mother to look after herself and his siblings. He said he was sorry but it was "time to go" and his life was not worth living any more. He also apologised to the person who had to cut him down.

90. The duty governor told all the prisoners on the wing of the man's death at 6.40am and they were allowed out of their cells to talk to each other. Those subject to suicide monitoring procedures were also checked and those who were friends with him were spoken with in more depth.

91. The chaplain was called into the prison. When he arrived at 7.50am, he went straight to the man's cell where he prayed over his body as his religion was registered as Church of England. Staff in the chaplaincy organised a memorial service for him in the prison chapel at 11.00am. Nineteen prisoners from his wing attended. The chaplain also spoke to the other prisoners on the wing.

92. Staff were seen by the care team that morning and were also interviewed by a governor. Two debriefs for staff were held, one that morning and another

around two weeks later. Staff said they felt very well supported in general. However, some staff said that they were on leave the following week and were not contacted during this time. They therefore found it more difficult coming back to work the week after. For example, an SO was asked questions by his team regarding the man which he could not answer as he had not been kept informed.

93. A duty governor and a Principal Officer (PO) were immediately appointed as family liaison officers. The duty governor, along with the chaplain, told the man's mother of his death at her home that morning. His mother wanted to inform his partner and father herself.

94. The PO told the man's mother that he had not left any letters in his cell since she was unaware that the police had already taken them. The police gave his mother a copy of them the following day. The PO remained in contact with the family. The prison offered to pay the funeral expenses and returned his property to them promptly. His partner visited the prison on 21 July and spoke to prisoners and staff who had known him.

95. One of the family's concerns was that they felt the PO inappropriately recommended that they see a medium following the man's death. My investigator spoke to the PO who explained that she had had some relevant personal experience and had been speaking about what had helped her situation. She said that she did not advise his mother to see a medium. It is clearly impossible to determine the exact nature of the conversation after the event but given the potential for misunderstanding or misinterpretation, it may be advisable to avoid discussion of such subjects in future.

96. I am aware that the man's partner said she was told by police that he had fresh cuts to his rectum. She wanted more information regarding this. At the time of completing this report I have not had sight of the post mortem report and am therefore unable to comment further. However, the coroner's officer told my investigator that the provisional cause of death has been registered as hanging. The toxicological report indicated that he tested negative for drugs and alcohol.

ISSUES

Monitoring under the suicide and self-harm procedures

97. The man had not been considered at risk of self-harm or suicide while at Altcourse and the same assessment was made by officers and healthcare staff when he transferred to Risley. The only time he was subject to ACCT procedures was on 24 May 2009, following his claim that his partner had suffered a miscarriage and he felt suicidal.

98. The following day, the man admitted that he had fabricated the story to try and get a telephone call to his partner. He denied any feelings of self-harm or suicide and the ACCT was closed appropriately. The post-closure review was set for 2 June. My investigator was told by the safer custody department that it took place. However, she has not had access to any documentary evidence to support this assertion. Whilst I do not make a formal recommendation in this regard, I would ask the Governor and head of safer custody to satisfy themselves that post-closure reviews take place and are documented as required.

99. The man made three telephone calls to his partner on 12 July, during which he said that he was considering suicide and had cut himself the previous evening. However, prison staff did not listen to these calls until after he had died. I have found no other evidence that he presented a risk of harm to himself and therefore assess that staff used ACCT measures in an entirely appropriate manner.

100. The clinical reviewer also made similar observations. He concludes, “My judgment is that while the man’s attempt at fatal self harm on 13 July 2009 was foreseeable it was not predicable or preventable.”

101. Both the man’s partner and his mother said that they had told the prison that they did not think he should be allowed to keep his belt as they were worried about the risk he may present to himself. However, this is not documented anywhere in his paperwork, nor did any of the staff recall such information being passed to them. The PO appointed family liaison officer told my investigators that any concerns regarding an individual would be logged by the duty governor and passed to relevant staff. I make no formal recommendation in this regard but the Governor might wish to satisfy himself that such information is being routinely passed on.

102. However, even if staff had this information, unless they assessed the man as at risk of suicide or self-harm, they would have been unlikely to remove his belt from him. Prison policy states that such items can be considered for removal if the prisoner is assessed to be at risk of harming himself. However, even in such situations, this decision is not automatic and must be taken after careful consideration. The removal of a prisoner’s personal belongings may cause them further distress and reduce their dignity.

Personal officer scheme

103. Staff at Risley were unable to tell my investigator who the man's personal officer was. At the time, a prisoner's personal officer was recorded on a board on the wing and, when the prisoner or officer moved wings, their name would be replaced. Thus, there is no record in the written documentation identifying his personal officer.

104. The Risley personal officer handbook outlines that each prisoner should have both a personal officer and reserve who are responsible for ensuring frequent contact with the prisoner. The guidance notes that a minimum of two quality entries must be made per month in the prisoner's history sheet. It goes on to say the personal officer contributes to:

> " … supporting a prisoner with any motivational issues, assisting him in accessing provision and utilising it appropriately, providing advice and guidance and receiving feedback from him regarding his progress through elements of his sentence plan … The personal officer is responsible for supporting the prisoner to sustain links with external agencies and support networks, families/carers and community facilities."

105. The handbook also says that personal officers are expected to attend ACCT reviews and complete a target sheet once a fortnight which should include information relevant to an individual's progress through his sentence. For example, his attitude, issues with other prisoners and family ties.

106. In her most recent inspection report of Risley, HM Chief Inspector of Prisons had concerns regarding the personal officer scheme at Risley and described it as "weak". From the information provided to my investigator, it was not possible to confirm whether the man had a personal officer and if he did, who this was. Certainly the guidance in the personal officer handbook was not followed and there are insufficient entries in his wing history sheet to determine this. It may have helped him to have a more personal relationship with an officer whom he could confide in, as well as providing a more consistent and cohesive approach to his issues. This is a matter of concern to his family as they were contacted by different members of staff asking for the same information. The contacts must be particularly distressing with the hindsight which follows his death.

107. Despite this lack of evidence regarding the man's personal officer, it should be noted that staff spent considerable amounts of time trying to verify issues which he said were upsetting him, despite him having fabricated stories on previous occasions. He also received appropriate care in relation to his chest pain despite suspicions that his symptoms may not be genuine.

108. I am aware that since the man's death Risley has drafted a new personal officer scheme policy which will shortly be introduced. A prisoner's personal officer is now also recorded on the National Offender Management

Information System (NOMIS), a computer system which has been installed at Risley since his death. I therefore make the following recommendation:

The Governor should satisfy himself that the personal officer scheme is operating effectively and in accordance with the local protocol.

Mental health referral

109. On 24 May, the man made inconsistent claims regarding his partner having a miscarriage. He accused his mother of lying that it was not true and the second SO of lying that he had telephoned her. The SO recorded that he made a referral to the mental health team by telephoning them and leaving a voicemail. He believed this would be actioned the following day. However, the mental health team manager said the team did not receive it and the usual process was to submit a written referral to the team's inbox. Therefore he did not receive any mental health support.

110. The clinical reviewer makes the following observation:

> "My reading of the referral is that it was based on the precautionary principle. In addition, the man had come into contact with other members of the healthcare staff including a GP. None of these professionals took the view that he had a mental health problem. His record from HMP Altcourse indicates that he had no documented history of mental illness or self harm.
>
> "In the light of the above my view is that, it is reasonable to assume that even if he had a post ACCT closure interview and been seen by the mental health team it is unlikely that his risk category of self-harm in the future would have been upgraded. It is arguable that he might have benefited from a mental health assessment. However it would be stretching any sensible reasoning to infer or assert that a mental health assessment would have led to a different outcome."

111. Despite this, it is crucial that there is clarity in the mental health referral process and those prisoners who need to be assessed gain the appropriate access to services. The SO believed he could complete a telephone referral, but the mental health team told my investigators that they require hand delivery of a written pro forma. It is of further concern that the mental health team did not receive the second SO's voicemail. The clinical reviewer also concurred that he believed mental health referrals may need to be more clearly communicated. I therefore make the following recommendation:

The head of healthcare should review the referral process for obtaining a mental health assessment and ensure all staff are aware of the correct procedure to follow.

Treatment of the man's chest pain

112. The clinical reviewer makes the following conclusion regarding the assessment and treatment of the man's chest pain:

> "Although he appears to have complained of chest pain over a period of time during his stay at HMP Risley, there were three [on 1 June, 21 June and 28/29 June 2009] times on which he called the night staff. On each occasion he was properly examined. An ECG was taken on each occasion and on two occasions he was sent to hospital, albeit that on the second occasion he was only taken to hospital as this was dictated by protocol.
>
> "He was also seen by a doctor at the prison on two occasions following the night time episodes of chest pain. A diagnosis of pain of musculoskeletal origin was made by the doctor and this was supported by the assessment in the accident & emergency department.
>
> "The plans to meet the man's needs were comprehensive. His symptom of chest pain was properly assessed and managed. His healthcare needs were sufficiently and appropriately assessed on reception and in custody at HMP Risley. He was assessed [correctly] to have no significant chronic or active physical or mental health problems."

113. Staff had some concerns as to whether the man's symptoms were genuine and there were security issues in taking him to an outside hospital. Despite this, they always acted in an entirely professional manner, making sure he had thorough assessments and was given the opportunity to receive treatment he required.

Going into cells at night

114. Having discovered the man hanging, the second OSG said he was instructed over the radio by the third SO not to go into the cell until someone else arrived. This was not confirmed by the SO, but in any event he told my investigators that in this situation he believed the OSG had acted correctly by remaining outside the cell. The SO said from the way the man was positioned it was an unusual way to be hanging and therefore may not have looked like a life threatening situation. Other staff made reference to the fact that he was not actually suspended off the floor but was "slumped".

115. However, when requesting assistance, the OSG said he thought a prisoner had committed "suicide" and that it was hanging. This indicates that he believed it to be a life threatening situation. The OSG believed he could go into a cell at night with Oscar One's permission if a prisoner was bleeding and he had a chance to stop the bleeding. The SO said that an OSG can go into the cell if they can save a life, but they must first of all inform the orderly officer that they are going inside.

116. Risley has a local policy which outlines the procedures to follow in the event of an actual or suspected death in custody at night. It says that if it can be done safely, the person discovering the situation should enter the cell and that if the person is hanging, they should support the body and cut the person down. They should place the person on the ground and check for signs of life, attempting resuscitation if assessed as appropriate.

117. Another protocol details when a cell can be unlocked at night using the sealed pouch. This says:

> "All wing patrols carry a sealed pouch (containing a cell key and class two key) attached to their chain. This is to enable the night patrol to respond quickly and open a cell door quickly if it is thought that a prisoner's life is in danger (ie fire, self-harm). The night patrol should exercise extreme caution when opening a cell door on their own and should consider the possibility that the incident is not genuine. The night orderly officer should always be informed by radio before a cell door is opened. Unless a life is obviously at risk then the presence of the night orderly officer should be awaited."

118. NOMS' Chief Operating Officer wrote to all Governors on 26 January 2010. This followed concerns raised by my office in previous investigations regarding staff understanding of when they can enter a cell at night. Although his letter was sent after the death of the man, it is clearly relevant to this investigation. He outlined that all staff must be aware of local procedures for what they should do if faced with a potentially life-threatening situation when there are no other staff in the immediate vicinity.

119. Given that the OSG said he had been instructed not to enter the cell, it is understandable that he did not do so. Other staff were also present very quickly at the man's cell to open the door.

120. However, I am concerned that the OSG believed the only situation in which he could enter a cell was if someone was heavily bleeding and he could stop the bleeding. The protocol makes reference to other emergencies when a prisoner may be in danger such as a hanging or if the cell is on fire and that if safe to do so the night patrol should enter immediately in such situations. However, I do also recognise that the man was not suspended from the floor and that this may therefore have given cause for confusion as the SO explained. I therefore make the following recommendation:

The Governor should ensure that all staff working at night, including Operational Support Grades, are aware of their roles and responsibilities, especially regarding going into cells in the event of an emergency.

The use of emergency codes

121. Following a death at Risley in 2007, I recommended that a code system should be introduced to use in emergencies, to help define the nature of the

emergency to those summoning assistance. Whilst my investigators saw evidence that this has been introduced, it is apparent that staff were unclear about its usage.

122. The SO said that emergency codes had been in place at Risley since around October 2008. These are code black for a potential hanging or if the prisoner is unconscious, code red if the prisoner was bleeding and code yellow for a less serious injury. The nurse said that she believed the codes in operation at the prison were white, red and yellow.

123. The OSG said that, whilst he was unaware of the codes to use in the event of an emergency, he believed that those senior to him would use them. As the nurse commented, even if the OSG had known the codes, the shock of discovering someone hanging or otherwise injured can often lead the person to forget to use the correct code. The OSG was clearly quick to respond to the emergency and, critically, he requested healthcare and management assistance, also verifying the nature of the emergency when asked.

124. None of the policies relating to night staff response to emergencies which were seen by my investigator detail the code system. They simply refer to the night patrol requesting emergency assistance. It therefore seems that, although these codes have been introduced, staff are not clear about their use. I therefore make the following recommendation:

The Governor should remind all staff about the correct use of emergency codes and ensure that advice relating to the code system is incorporated into all the policies relating to an emergency response.

CONCLUSION

125. The man had been in prison for most of his adult life. During his most recent sentence from January 2009, he was not considered a risk of self-harm or suicide. I judge that this assessment was sound. The period of around 24 hours during May 2009 when he was on an ACCT was a result of a lie he told about his partner to obtain a telephone call to her. He subsequently denied any thoughts of suicide or self-harm.

126. Staff took considerable time to try and verify the difficulties the man said he was experiencing, whether connected to his partner or when he said his son was in hospital. They also ensured that he received the appropriate assessment and treatment chest pain despite their concerns as to whether these symptoms were genuine. I have found that staff acted with patience and compassion for him.

127. The prisoners who knew the man said he was becoming increasingly upset about being unable to see his partner in the days before his death. However, he seemed to be making plans for the future and had applied to move to a prison nearer his family and friends to make their visits easier. No one, staff nor prisoners, believed he was a risk to himself and his death came as a shock to all those who knew him. He did not share the depth of his distress and I am satisfied that nothing could have been to prevent his death.

RECOMMENDATIONS

1. The Governor should satisfy himself that the support officer scheme is operating effectively and in accordance with the local protocol.

   This recommendation was accepted. Series of Personal officer briefings and awareness sessions have been conducted. Awareness training is continuing to be carried out on Induction for relevant new /transferred in staff.

2. The head of healthcare should review the referral process for obtaining a mental health assessment and ensure all staff are aware of the correct procedure to follow.

   This recommendation was accepted. A new system has been implemented which complements the verbal request for a mental health assessment. The requestor now completes a carbon copy assessment referral form a copy of which is kept in the ACCT document. The system has now been embedded and is monitored by the Safer Custody Manager

3. The Governor should ensure that all staff working at night, including Operational Support Grades, are aware of their roles and responsibilities, especially regarding going into cells in the event of an emergency.

   This recommendation was accepted. Night operating procedures were reviewed in July 2009. A further review of procedures was carried out in February 2010 and implemented in way of an LSI and LSS.

4. The Governor should remind all staff about the correct use of emergency codes and ensure that advice relating to the code system is incorporated into all the policies relating to an emergency response.

   This recommendation was accepted. A new code system was introduced in March 2008. Also, the safer custody PO has carried out a series of staff briefings and awareness sessions for all directly and non-directly employed staff w/c 12 July 2010. To date 8 Roadshows have been attended by 87 staff. Further Roadshows are planned to inform staff in remaining areas including night staff.

FAMILY RESPONSE

1. The report was sent to both the man's mother and his partner. His mother asked for clarification regarding the prisoner's comment during interview that the man had a broken rib and marks on his legs. I have found no evidence of either of these injuries in his clinical record or other documentation. His chest pain had always been diagnosed as muscular. Without sight of the post mortem report I am unable to comment further.

2. The man's friend told my investigators that a card and collection had been made following the man's death. His mother asked where this had been sent since she had not received anything. The prison financial department were unaware of prisoners withdrawing any money from their accounts for this reason. The man's friend has since been released from the prison and, at the time of writing, further enquiries were being made with other prisoners and staff on the wing.

3. The man's partner continued to question why he was allowed to keep his belt. She said she had spoken to an officer who said he had concerns about his mental health and she asked the officer to remove his belt. His partner also confirmed that she had a miscarriage around the end of January 2009.