Investigation into the circumstances surrounding the death of a man at HMP Swaleside in April 2010

Report by the Prisons and Probation Ombudsman for England and Wales

October 2011

This is the report on an investigation into the circumstances of the death of a 46 year old man who apparently took his own life in HMP Swaleside in April 2010. I offer my condolences to the man's family.

One of my family liaison officers spoke with the man's family to explain our role and offer the opportunity for them to be involved. I would like to thank the man's family for their contribution to this investigation under such distressing circumstances. I hope that my report answers their questions. I apologise for the delay in issuing this report, and the additional distress which this has undoubtedly caused.

The investigation was undertaken by a senior investigator. We would like to thank the Governor of Swaleside and his staff for their co-operation. I commissioned a review of the man's clinical care whilst in custody, which was carried out by a clinical reviewer on behalf of Eastern and Coastal Kent Primary Care Trust (PCT). I am grateful to him for his review and his contribution to my investigation.

The man had been in prison for a number of years and moved, unsuccessfully, to open conditions on more than one occasion. He was diagnosed with a personality disorder and depression and had recently returned from a period in a specialist hospital. He had been referred back to the Parole Board and received the reports on his conduct four days before he took his life. The man had made a number of attempts on his own life over the years and, when he took his life, was again being supported by the prison's monitoring measures for those thought to be at risk of harming themselves.

In the draft of this report my office made nine recommendations. The first was a national recommendation concerning sentence planning. The draft commented on prisoners' medical appointments, the personal officer scheme, monitoring prisoners subject to self harm monitoring and the actions to be taken when a prisoner is found hanging. The draft also considered the family's view of the information and support which they received from prison staff and made another recommendation regarding relationships with bereaved families.

I am pleased to see that the National Offender Management Service has accepted eight of the recommendations and partially accepted the other. I am also particularly grateful to the man's family for their detailed and considered response to the draft. I hope the amendments in this final report go some way to addressing their concerns.

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

Nigel Newcomen
Prisons and Probation Ombudsman **October 2011**

CONTENTS

SUMMARY

1. The man was convicted of murder and sentenced to life imprisonment in 1991. He had therefore spent many years in prison. He had progressed through the system and had on three occasions been transferred to open conditions (a lower security prison where prisoners have a greater degree of trust). He found it difficult to adjust to these moves and each time had moved back into closed conditions, once at his own request.

2. The Parole Board considered the man's case in December 2007. The Board did not recommend a return to open conditions but asked for him to be referred back in December 2009 to enable the man to work with a psychologist to understand the motivation for his offence. The Board also recommended that he should undertake a cognitive skills booster course (an offender programme to help prisoners recognise and understand their thought processes in relation to their offending) and work on forming alternative coping strategies.

3. The man transferred to HMP Swaleside in January 2009, and in June of that year was found hanging in his cell. Staff managed to cut the ligature and he was treated in the healthcare centre. This was the latest of a number of apparent suicide attempts that he had made through his sentence. He was put on special measures to support those felt to be at risk of harming themselves (known as Assessment, Care in Custody and Teamwork – ACCT).

4. As the Parole Board were due to consider his case in December, the prison began to collate reports to put before the Board. In early August, the psychology department submitted a note, saying that they would not prepare a report as the targets set in the last psychological assessment had not been completed, and the department was unable to carry out this work.

5. Arrangements were started to assess the man for a transfer to a hospital for the treatment of prisoners with mental health needs, and he moved there in December. December was also the month when the man's case should have been referred back to the Parole Board. As he had been transferred to hospital, the process was put on hold until he returned to prison. Although his family felt that he seemed to settle well at the hospital, the man had some difficulty with the regime there. In February 2010 he asked to be returned to prison. Staff encouraged him to stay but, over the forthcoming weeks, his frame of mind deteriorated. By early March, staff at the hospital decided that his motivation had decreased to the extent that he should return to prison.

6. On arriving back at Swaleside, the man threatened to harm himself if he was not placed in healthcare. Although he was persuaded that it was in his best interests to remain on ordinary location, he was placed under the ACCT support measures as a precaution. It appears that he may have been buying drugs from other prisoners and had got into debt. Arrangements were made for him to collect his medication at a different time from other prisoners, so that he would not encounter those to whom he may have been indebted.

7. The man's papers had been collated to be referred to the Parole Board once again. They were disclosed to his legal representative on 23 March, and then to the man himself on 29 March.

8. Although a friend said that the man had seemed a bit down, there were no serious, immediate concerns about him. He remained subject to ACCT support and was checked by staff once per hour. He continued to express concerns about his future.

9. On a day in early April, the man slept all morning and declined to collect his lunch, telling staff that he was okay. The prisoners were then locked in their cells for the lunch period. Staff checked on the man at 12.58pm, when no concerns were reported. The staff unlocked the cells on the man's landing at approximately 1.45pm. As the officer unlocked his cell, she looked through the observation hatch and saw him apparently standing facing her. She unlocked the door and moved on.

10. However, a few seconds later, some prisoners went into the man's cell and found that he was hanging. They raised the alarm, and staff arrived quickly. They cut him down and worked to resuscitate him. Prison healthcare staff attended, and attempts at resuscitation continued until an ambulance crew arrived and took over. The resuscitation efforts proved unsuccessful and his death was declared by the ambulance crew.

11. The prison contacted the man's next of kin. He died on Easter weekend, when the prison's only trained family liaison officer was on annual leave. He came in to the prison to contact the family but, after giving details of what had happened, he told them that he was on leave for the following week and no one was covering the position. Relations between the prison and the family became strained, and eventually another member of staff acted as the liaison.

12. I make nine recommendations. The first is to the National Offender Management Service and concerns sentence planning. The other recommendations address outstanding medical appointments, the personal officer scheme, monitoring prisoners subject to ACCT procedures and the actions to be taken on finding prisoners hanging. I also recommend that steps are taken to address any difficulties between a bereaved family and the family liaison officer.

THE INVESTIGATION PROCESS

13. My investigator was given full access to all relevant records relating to the man, including his prison and medical files. During the investigation he visited Swaleside and spoke to that staff responsible for the man's care, and the prisoners who knew him. He interviewed six members of staff and one prisoner, and all but one of these interviews were recorded. The other interview was conducted over the telephone. Copies of the transcripts were sent to the interviewees to confirm their accuracy. My investigator also spoke to the Acting Governor and the vice-chair of the Independent Monitoring Board. My investigator made himself available to speak to the Prison Officers Association and the chaplaincy.

14. Notices were posted to staff and prisoners about my investigation, inviting contributions if necessary but none were received. My investigator had access to statements made by relevant staff after the man died.

15. Eastern and Coastal Kent Primary Care Trust (PCT) asked a clinical reviewer to carry out a review of the man's clinical care. I am grateful to him for undertaking this review. Unfortunately, there was a delay before the clinical reviewer was appointed and his review was not received until late February 2011 which is why my own report is late. My investigator discussed aspects of the man's treatment both with healthcare staff at Swaleside and with the reviewer.

16. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and request a copy of the post mortem report. My report will be sent to the Coroner to assist in his enquiries into the man's death.

17. One of my Family Liaison Officers (FLOs) spoke with the man's niece, who was the point of contact on behalf of her mother (the man's listed next of kin). She told her of my investigation and invited her and the man's family to ask any questions or raise any issues for consideration. My Family Liaison Officer and investigator met with the man's sister, niece and brother-in-law to discuss the investigation and listen to their concerns about the care which the man received. His family asked if my investigation could consider the following issues:

    - the level of psychiatric support he had received, both before and after the period spent at the hospital for the treatment of prisoners with mental health needs
    - the limited engagement of the Probation Service throughout the man's sentence
    - the arrangements regarding the man's Parole Board review whilst he was at the hospital for the treatment of prisoners with mental health needs
    - the appropriateness and quality of any self-harm monitoring
    - the appropriateness of the actions of the officer who unlocked the man shortly before he was found hanging

- the quality and appropriateness of the family liaison arrangements following the man's death.

18. At the suggestion of the man's family, my investigator also spoke to the man's prison law consultant about some of the issues raised. I have done my best to address the concerns raised by the man's family, including their helpful and detailed comments on the draft report. I hope my report helps them better understand the events leading to the man's death.

HMP SWALESIDE

19. Swaleside is a category B prison (for prisoners not requiring top security conditions, but for whom escape must be made difficult) which is part of the three prison cluster on the Isle of Sheppey in Kent. It holds long-term prisoners, including a large number on indeterminate sentences (serving sentences of no fixed length but until the risk to the public is judged to have been reduced), who have more than 18 months left to serve on sentences of at least four years. It had an operational capacity of 1,132 as of February 2010.

Healthcare

20. There is a daytime general practitioner service from Monday to Friday and an out of hours service provided by South East Health. The healthcare staff include the healthcare manager, nurses, healthcare officers and a pharmacy technician. Primary care services include a Well Person Clinic for long-term illnesses such as asthma or diabetes, primary and secondary mental health care, Integrated Drug Treatment Service (IDTS), sexual health, optical care, dentistry, physiotherapy, radiography, weight management, blood clinics, and palliative care. The prison has an 18-bed in-patient unit for prisoners with physical or mental health problems, which is staffed 24 hours a day.

Suicide and self harm monitoring

21. Assessment, Care in Custody and Teamwork (ACCT) is the system used by prisons in England and Wales to monitor and support prisoners assessed as at risk of suicide or self harm. Once placed on ACCT, the prisoner is supervised at regular intervals according to the perceived level of risk.

22. Each prisoner is assessed within 24 hours and then reviewed at intervals decided on an individual basis. The ACCT guidance says that, to be effective, the review should involve the key people, forming a case review team, who know the person at risk or are involved in their care. The key questions for each review are listed as:

- Have the problems that caused the ACCT plan to be opened now been resolved?
- If not, what needs to be done to resolve them?
- Have any further problems arisen that are now causing distress and more risk?
- If so, what action can be taken to address these?
- Is the person at risk now in contact with friends, family or other support?
- Does the person at risk now have something in their lives that they feel good about?
- If not, how can this be improved?

23. Over time, the reviews should also consider other factors such as:

- Distress – has anything changed to make the person at risk more or less desperate?
- Resources – has anything changed that makes the person at risk now feel more or less alone?
- Previous suicidal behaviour – has anything changed that makes suicide more familiar or more acceptable to the person at risk?
- Suicide intention or plan – has anything changed to show that the person at risk is either more or less prepared to kill themselves?
- Pattern of self harm – is self harm becoming more or less frequent?

24. An ACCT plan can be opened by anyone working in the prison. An ACCT should be opened when anyone has any concerns whatsoever that a prisoner may be at risk of harming him or herself. Among other things, the ACCT guidance states that prisoners should be cared for in a safe environment and the case review team decide the most appropriate place to locate an individual prisoner.

25. Once it has been agreed that ACCT support is no longer required, a post-closure interview must be held to ensure that problems have been resolved or reduced and that the level of risk has sufficiently dropped. The date for the interview is a matter for the case review team to decided, but it must be within seven days of the ACCT support coming to an end.

Parole for mental health patients

26. All prisoners who are compulsorily admitted to hospital under the Mental Health Act have their parole process suspended whilst they are in hospital. If they are prisoners who have served their sentence, they can be released into the community to go to hospital. If they are serving indeterminate sentences, the parole process is suspended for the duration of their hospital stay.

Previous deaths at HMP Swaleside

27. Since my office took over responsibility for investigating deaths in custody in April 2004, there have been 17 deaths in Swaleside prior to this man's, five of which were self-inflicted. There have since been two further deaths, one of which was self-inflicted. My office's previous reports have also made recommendations about family liaison matters.

Her Majesty's Inspectorate of Prisons

28. The last inspection of Swaleside by the Her Majesty's Chief Inspector of Prisons was an announced inspection in April 2008. The inspectors found Swaleside to be a safe and respectful prison, which was impressive given the many serious offenders held. The report was positive about the overall operation of the personal officer scheme, but made a recommendation which included ensuring that the expectations of personal officers were clear. In

considering ACCT procedures, the report noted that the standards were variable.

Independent Monitoring Board

29. Each prison in England and Wales has an Independent Monitoring Board made up of unpaid volunteers from the local community appointed by the Secretary of State for Justice. The Board is responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained.

30. The report published for the year 2009-10 by the IMB for Swaleside noted that the psychology department was understaffed, that the prison has no policy that makes an explicit link between educational need and offender progression, and that there were delays with parole reports. The report says that there is a significant drug problem in the prison.

KEY EVENTS

31. The man was convicted of murder in 1991. He had been staying with a man he met whilst hitchhiking, and claimed that the man came into his bedroom with a knife and sexually attacked him. In the ensuing struggle he stabbed and killed the man.

32. Sentenced to life imprisonment, the man moved through the prison system. He undertook a number of offender courses (courses which help prisoners address areas which may have contributed to their offending), including Enhanced Thinking Skills, and anger and stress management courses. He also took further education courses, gaining academic qualifications in art, mathematics, and English.

33. In 1997, the man disclosed that when he was a child, he had been sexually abused. This happened when he was a pupil at a school for blind children, and the alleged perpetrator had been a teacher there.

34. The man served his sentence in a number of prisons. In August 2000, while at HMP Wymott, he made an attempt to take his own life. He was found with a ligature around his neck, which was safely removed.

35. After some time in HMP Lindholme and HMP Latchmere House, the man was transferred to HMP Doncaster on 16 July 2001. Whilst there, in April 2002, he was assessed for Post Traumatic Stress Disorder (PTSD: a psychological and physical condition caused by very frightening or distressing events. The person often relives the event through nightmares and flashbacks. They may have problems concentrating and sleeping, and feel isolated and detached). The prison psychologist concluded that the man suffered from a PTSD which was rated as severe. This appeared to stem from a number of traumatic events in his life. The man specifically identified the sexual abuse and the death of his victim as the causes, although the report does not make clear if he meant the abuse which he said he suffered as a child, or whether he meant abuse by the victim of his offence.

36. By early 2003, the man was judged ready to be transferred to open or Category D conditions. (These are prisons with low security, designed for prisoners who can be given a higher degree of trust, are less likely to escape, and who are thought to pose a low level of risk to the public.) He moved to HMP Wealstun on 13 February 2003. However, he had trouble coping with the new regime and he went on a town visit a week later but did not return. After remaining unlawfully at large for just over a week, the man gave himself up on 28 February. He was returned to closed conditions, initially going to HMP Bullingdon on 1 March, before transferring to HMP Bedford, and then on to HMP Haverigg on 16 April. After two months in HMP Risley, the man was transferred to HMP Ranby on 8 October.

37. The Parole Board considered the man's case on 23 July 2004, and recommended that he was ready once more to move to open conditions. On 21 September he transferred to HMP Kirkham. However, on 20 October, the

man told staff that he felt as though he was at risk of absconding. He was finding it difficult to cope, and felt that he was receiving little support for his PTSD. He asked to go back to a closed prison and, on 21 October, he returned to HMP Ranby, a category C prison.

38. After contact with staff at Ranby and at Kirkham, the Secretary of State agreed that the man could once again return to open conditions without referral to the Parole Board. On 15 March 2005, he was transferred to HMP Hewell Grange, another category D prison. He was released on temporary licence for an unescorted town visit a month later on 16 April. He smelt of alcohol when he returned that evening, and was unsteady on his feet.

39. Nevertheless, approval was given for a period of five days home leave in July. Arrangements were made for the man to stay in an approved probation hostel. He was given a drug test beforehand and the results, which were positive for opiates and cannabis, were given to him whilst he was at the hostel. He remained at the hostel, but then decided not to return to custody and absconded. He was found by the police on 16 July, and returned to closed conditions. He arrived in HMP Manchester on 18 July, before moving on to HMP Featherstone on 3 August.

40. In December 2005, the man's solicitors arranged for a psychiatric report to be prepared for the Parole Board. This report gave the opinion that he displayed symptoms of PTSD, but not the full syndrome and neither did he suffer from a personality disorder. He had significant personality traits such as anxiety and emotional instability, and it seemed clear that he would require significant support to move from prison back into the community.

41. The Parole Board considered the man's case in January 2006 and identified specific areas of work which he should undertake in order to progress. He should take the cognitive skills programme, undergo in-depth work to explore the motivation for his offence, and be assessed by a forensic psychologist to establish the impact of past psychological experiences and personality problems.

42. During the morning of 3 August, the man pressed his cell bell. He was subject to ACCT support at the time, and staff found him with a ligature, made from a shoelace, around his neck. Staff removed the ligature and no treatment was required. He remained in Featherstone for a short while longer and then transferred to HMP Lancaster on 20 October.

43. The man felt that he was having difficulty obtaining proper cooperation from the Probation Service. Having been unsuccessful whilst he was in open prison, he wanted to find out about going to a Langley House hostel instead. Langley House is a charitable institution which helps offenders to adapt from the prison environment to the community. In order to consider the man's referral, Langley House needed some documentation from the Probation Service. The service did not consider that Langley House was appropriate and did not forward the necessary papers. Through his legal representative the man threatened to take the issue to a judicial review in February 2007.

The service agreed to forward the documents which were accompanied by a letter which did not support the move.

44. The files show nothing of particular significance until the morning of 10 July 2007. The man rang his cell bell and told staff that he had tried to hang himself from his window. He had managed to free himself, but was upset. He had got into debt with other prisoners, and was being pressured. He was transferred to HMP Wolds on 16 November.

45. Intelligence indicates that the man got into debt again fairly quickly. On 24 December, he set fire to his cell in the segregation unit, where he had been taken after failing to comply with the prison regime. He was placed on ACCT support, and remained so until 6 January 2008.

46. The Parole Board considered the man's case on 20 December. The reports for the Board generally agreed that he was not yet ready to be re-tested in open conditions. The psychologist's report considered the explanation which the man had given for his index offence. He said that, whilst staying at his victim's house, his victim had come into the man's bedroom with a knife. The man now maintained that he had been raped at knifepoint, something which he had not revealed previously. The trial judge had described the man's version of events as "highly improbable" and medical evidence suggested that the victim had a knife held to his throat for some time. The psychologist also suggested that there was no corroboration for the man's claims to have been abused whilst a schoolboy. She was concerned that the man denied any homosexual preferences, although there was evidence to support them. The man was unhappy with the report and was also concerned that a single report cast serious doubt on his account of events. He was also unhappy with the Probation Service representation at his parole hearing. His usual probation officer was not available and so another probation officer, whom he had not met before, attended instead.

47. The man received notification of the Board's decision on 9 January. The Board had not recommended that he should be released or transferred to open conditions. His case would be referred back to the Board in December 2009 to enable him to undertake work previously identified, including in-depth work with a psychologist to explain his motivation for the index offence. The Board also recommended that he should undertake a cognitive skills booster course and work on forming alternative coping strategies.

48. The man transferred to HMP Altcourse on 20 February 2008, and on to HMP Rye Hill on 19 May.

49. On the evening of 3 September, whilst at Rye Hill, the man pressed his cell bell and staff found that he had cut his wrist. He was treated, taken to the healthcare centre, and placed on ACCT support which remained in place until 16 September. A note in the man's medical file indicates that, on 30 October, he took 38 paracetamol tablets, together with an amount of a prescribed drug he was taking. He was very tearful and depressed, saying that he wanted to

die. He was referred to outside hospital and, on his return to prison, was again placed on ACCT support.

50. As part of his sentence progression, the man transferred to HMP Swaleside on 27 January 2009. On 11 February, he cut his wrist and needed treatment from healthcare staff. He told staff that he was having problems with drugs, and was under pressure to pay for them. He was once again placed on ACCT support.

51. A report on 2 June indicates that the man had been bullied by at least one other prisoner. Before any action was taken, he was moved to the segregation unit after refusing to go into his cell when it was due to be locked. (Separately, the alleged main perpetrator had also moved from the wing.) The man's mental state was assessed on 8 June whilst he was still in the segregation unit. (Segregation units are separate from the ordinary prison wings, and prisoners are held either for their own protection or to ensure the good running of the prison.) His mood was depressed, and he felt hopeless without a transfer to another prison on the horizon. He had written to his solicitor, describing his low mood, hopelessness and thoughts of suicide.

52. On 11 June, the man was found hanging from a window in the shower room. He had made a ligature from his bedclothes. Staff cut him down, and he was treated in the healthcare centre. He remained on ACCT support until 20 June.

53. The prison psychiatrist reviewed the man the next day, 12 June. He told the doctor that his mood had deteriorated over the previous month, in light of an assessment by an independent psychologist. He was concerned that he might be transferred to a Dangerous People with Severe Personality Disorder (DPSD) Unit. (DPSD units treat prisoners who are considered to pose a high risk of harm to others.) The prospect of going to a DPSD unit had brought up memories of childhood sexual abuse and his index offence.

54. The man was due to be considered again by the Parole Board in December and so the relevant prison departments were asked in July for the necessary reports. On 3 August, the forensic psychology department returned a note saying that a psychology report would not be submitted for his parole dossier because the targets set in the last psychological assessment (in April 2007), following the previous Parole Board request, had not been completed. The Sheppey Cluster forensic psychology department was not funded for one-to-one work with prisoners and so they were unable to complete the work recommended by the Parole Board in 2007.

55. In view of the previous recommendations that the man needed psychological input, consideration was given to whether he would benefit from treatment at a centre for forensic mental health. Based at the hospital for prisoners with mental health needs, the unit provides in-patient treatment for offenders who are suffering from a mental disorder which cannot be managed by general psychiatric services.

56. The assessment process began and the man had a psychiatric assessment on 1 October. The assessment concluded that he suffered from Antisocial Personality Disorder, Avoidant Personality Disorder, and probable Obsessive Compulsive Personality Disorder. (Personality disorders are patterns of perceiving, reacting and relating to other people and events that are relatively inflexible and impair their ability to function socially.) Additionally, the man showed evidence of Recurrent Depressive Disorder (a tendency to suffer repeated periods depression), substance misuse (the assessment described him experiencing symptoms of physical dependence on heroin), and symptoms suggestive of Post Traumatic Stress Disorder. There were discrepancies in his account of his childhood and the motivation for his offence, which would benefit from further exploration. It was thought that he could benefit from the treatment programmes offered at the hospital for the treatment of prisoners with mental health needs and so he was referred for further assessment.

57. A nursing assessment was carried out on 15 October. The man appeared motivated to engage with the treatment at the hospital, and again it was thought that he would benefit from admission.

58. The man moved to the hospital for the treatment of prisoners with mental health needs on 8 December. Initially he was anxious and only participated in meetings in a small way. But he said that he found the environment positive and supportive, and his family believed that he was settling well. However, he told staff that he would find it difficult to explore childhood experiences or his offence in a group setting. Towards the end of December, he made it known that he was considering returning to prison as he was uncomfortable with the attitudes of some other patients. In early January 2010, he continued to express concerns, feeling uncomfortable and finding it difficult to participate, to comply with the ward rules, and live so far from his family. He was encouraged to stay and cooperate with his treatment, which he agreed to do.

59. Throughout January, the man said that his mood was deteriorating and the unit reminded him of the boarding school which he attended as a child. He was having difficulty engaging with the treatment and said regularly that he wanted to return to prison. He began to withdraw from his treatment but was again encouraged to stay and try to engage.

60. When a prisoner is transferred to hospital for long term mental health treatment, their Parole Board reviews are put on hold until they return to prison. This was the case with this man, who the Board had been due to consider in December 2009. His family gained the impression from him that he liked being in the hospital and felt that he was benefiting from being there, but that he was concerned about the delay to the Parole Board hearing. His family thought that this was the reason why he wanted to return to prison.

61. The man continued to experience problems with his eyesight, which were exacerbated when he was hit by a snowball in early January. He was referred to an optician, and checked at outside hospital for possible glaucoma, although the results were inconclusive.

62. On 17 February, the man complained of a headache, and said that he had passed out three times over the weekend. The following day he said that he passed out again, though he recovered quickly. He saw a doctor and his antidepressant medication (the man had been taking anti-depressants for some years) was adjusted. He complained of passing out on the next two days, but an electrocardiogram (ECG, an electrical recording of the heart) and his other clinical observations (such as blood pressure and pulse rate) were normal.

63. In a session with his psychologist on 22 February, the man produced a letter which appeared to express suicidal thoughts. He was encouraged to think of ways of keeping himself safe. The following day he saw a doctor in connection with losing consciousness. It was thought that this could be stress related but, as a precaution, he was urgently referred to the neurology department.

64. It was noted on 24 February that the man said that he wished to return to prison. He said that he was depressed, although staff said there was no consistent evidence of this condition. But he was becoming more distressed about remaining in hospital, and losing the motivation to engage. He was found with unauthorised items in his room and said that he wanted to go on to the roof in order to jump off. He was transferred to another room, initially against his wishes.

65. At a multi-disciplinary meeting on 8 March, it was agreed that the man was not showing enough motivation to benefit from treatment in the unit and should be transferred back to prison. He would be reassessed with a view to returning to the hospital if he showed more insight into his difficulties and increased motivation for treatment.

66. Staff at the hospital noted that, on his return to prison, the man should initially be located in the healthcare centre, remain on his current medication and engage with the psychiatric team to review the difficulties which he had experienced at the unit. He should be encouraged to find appropriate solutions to difficulties. It was also noted that he had outstanding referrals to an ophthalmologist (eye specialist) and a neurologist (dealing with the nervous system).

67. A doctor at the hospital provided a detailed discharge summary, which was dated 8 March. He said that the man said that he had used heroin, cocaine and ecstasy since coming into prison. He described developing symptoms of physical dependence on heroin earlier the previous year whilst he was at HMP Swaleside, saying that he engineered a move to the segregation unit in order to stop using drugs. He claimed to have last used heroin six months previously. He described regularly getting into debt as a result of his drug misuse, and believed it likely that he would be tempted to misuse drugs again if he was on normal location.

68. The man returned from the hospital for the treatment of prisoners with mental health needs to Swaleside on 11 March. He was initially allocated to the healthcare centre, to assist his transition back to the prison environment but, on 14 March, he was told that a single cell on D wing was ready for him. On hearing this, the man threatened to harm himself with a razor blade if he could not remain an in-patient in the healthcare centre. He needed support, and in view of his threats to harm himself, an ACCT plan was opened at 10.00am.

69. Staff were aware that the man had harmed himself in the past. The level of supervision (the number of times staff must have some meaningful interaction with him) was set at once per session when the man was out on association, every 15 minutes during patrol time, and once per hour during the night.

70. The first ACCT review was held at 3.00pm that afternoon. The man said that he felt most vulnerable when he was locked in his cell. He said that he felt low and paranoid about mixing with other people. He tried to use his time constructively, either cleaning or doing art work. The level of supervision remained unaltered, and the next review was set for 18 March, when the mental health in-reach team (MHIT) would also be invited.

71. Following discussion with a member of the mental health in-reach team on 16 March, it was agreed that it would be in his best interests to remain on normal location. He would remain on the team's case load and see the prison psychiatrist, after which a care plan was to be set in place.

72. When he had returned to Swaleside from hospital, the man had met up with a fellow prisoner whom he had known earlier in his sentence. The fellow prisoner had recently arrived in Swaleside and the man seemed pleased to have a friend on the wing. They were seen interacting frequently and well.

73. On 19 March, the man told a member of staff that he had not collected his medication for two days. He said he was being bullied by another prisoner when he went to healthcare. He refused to give names, but said that he had had trouble with this person previously. The fellow prisoner whom the man had known earlier in his sentence told my investigator that, rather than being bullied, the man had got into debt for buying medication from other prisoners. Arrangements were made for him to collect his medication earlier than usual so that he did not encounter people to whom he was indebted whilst collecting it.

74. A review of the man's ACCT plan was held on 20 March. The papers do not make clear why this did not happen on 18 March as planned. The record does not show that the MHIT attended as had been planned. It was apparent that the man remained very upset and wondered if he had made a mistake by returning to Swaleside.

75. The ACCT caremap notes that the man was to be encouraged to interact more with staff and prisoners on the wing, in order to feel safer there. Staff were to try to ensure a safe environment for him, in order to stop him from wanting to move to healthcare. The Regimes Department (responsible for

planning for prisoners) would assess targets for him as he felt that he had no goals. The man was reminded that he could speak to staff and/or the Listeners (prisoners trained by the Samaritans, who provide a confidential support service to other prisoners) if he wished. Supervision by staff was increased to one observation per hour at all times. When staff checked on him later that afternoon, he seemed to be content with the advice to speak to staff if he felt low. He handed over a home-made noose.

76. It was noted on 21 March that the man had not collected his medication the previous day and so the drugs were taken to him that afternoon.

77. An extra ACCT review was held on 22 March, after one of the man's friends died. He was upset when he heard the news and asked to see the chaplain. He told the chaplain that he felt isolated on the wing after all the support he received in the hospital. He was encouraged to come out of his cell as much as possible and mix with the others. That afternoon, the man asked to speak to a Listener.

78. Many prisons operate a personal officer scheme which allocates an officer to each prisoner. The officer's role is to offer support, be the first port of call for any queries, and generally keep a watch on the prisoner and their well-being. On 27 March, the man was allocated a personal officer. However, the officer told my investigator that he had no training to be a personal officer and was not told that he was expected to carry out the role for the man. He was not aware that the man had been allocated to him until he noticed that he appeared on his list of prisoners on his computer profile. The officer said that he had no significant contact with the man, who seemed distant. The officer said that the man only had any interaction with his friend or with other staff in connection with the man's ACCT plan.

79. On his return to prison, the process to refer the man's case back to the Parole Board resumed. The dossier was completed and disclosed to the man's solicitor and to the Parole Board on 23 March. A copy of the dossier was given to the man on 29 March. The papers were due to be taken through the Intensive Case Management (ICM) process. (ICM ensures that the relevant information required by the Parole Board is accurate and up to date.) Because of the short time since he returned from hospital, the date for the Board to consider his case had not yet been made.

80. A management check was made of the ACCT plan on the morning of 27 March. The manager noted two omissions: no trigger warnings were noted on the form and the care map had not been signed by the man.

81. The next ACCT review was held later that day. The man reported still feeling low, and was upset about his parole report. He mentioned wanting to move to a prison in the north. It was agreed that his personal officer would help him to make a transfer application as well as helping him to apply for accumulated visits. (Accumulated visits mean that the prisoner moves temporarily to a prison near to their family to receive the visits which have not been taken because the family live too far away.) In the meantime, the man was content

for the level of supervision to remain the same as previously. The next review was set for 3 April.

82. According to his fellow prisoner and friend, the man was “a bit down” at the end of March. He told his friend that the Parole Board had not yet seen his dossier and he was concerned about his sister, who he said was suffering from cancer.

83. During the course of the investigation, my investigator was told that on 1 April the man bought and took some heroin. There is no further intelligence to confirm or deny this.

84. The vice-chair of the Independent Monitoring Board for Swaleside saw the man during the course of her work on 2 April. She told the investigator that the man expressed concern for his sister, who he said was suffering from cancer. But other than being worried about her, she thought that he appeared to be in a good mood.

85. The man also spoke to his sister on the telephone that day. She told the investigator that her brother seemed to be in good spirits, and was looking forward to receiving some headphones that she would be sending to him. Likewise, the man’s fellow prisoner and friend saw no indication that the man was intending to harm himself, saying that he was making plans for his canteen order the following Tuesday.

86. Nothing untoward came to light during the night before the man’s death. Staff checked on him once an hour as set down in the ACCT caremap and, if he was asleep, they ensured that they saw some movement. All the cells were unlocked at 8.45am the following morning, at which time the man remained asleep. According to the ACCT plan ongoing record, he was not checked by staff again until 10.47am when he was still asleep, and movement was noted.

87. When he was next checked at 11.55am, the man remained asleep. On this occasion the member of staff woke him up as he had not collected his lunch. The man told the officer that he was not hungry but was otherwise alright. The officer said that she would return to check on him again soon. Fifteen minutes later, at 12.10pm, a further officer checked on the man again at approximately the same time when the cells were due to be locked for lunch. He was once again asleep and again the officer noticed some movement.

88. At 12.15pm, a further officer checked on the man and five minutes later, at 12.20pm, the cells were locked for the lunch period. The officer again checked on the man at 12.58pm, when he was lying on his left side. The officer made sure that he was moving and breathing.

89. All the cells on E wing were unlocked after lunch at approximately 1.45pm. An officer unlocked the cells on the man’s landing. She looked through the observation hatch of the man’s cell and saw him apparently standing, facing her. She then unlocked the cell and continued along the wing (officers do not ordinarily go into cells when they are unlocking the doors).

90. Very shortly afterwards, within a minute, some prisoners went into the man's cell. They found him hanging from the window bars, using a ligature made from bedding. One of the prisoners supported the man's body while the others called for help.

91. Two officers were both on the stairs a few feet from the man's cell and they heard the prisoners' calls. They went straight to the cell and, on seeing what had happened one of the officers told her colleague to raise the alarm. Using her cut-down tool the officer cut the ligature and together they lowered the man to the floor. The officer put the man into the recovery position and told everyone else to leave the cell.

92. A Senior Officer (SO) was on duty on E wing and responded to the alarm. He ran to the cell, arriving at approximately 1.50pm. The senior officer took charge and immediately began to perform cardio pulmonary resuscitation (CPR), undertaking chest compressions and asking his colleague to manage the man's airways (what used to be termed mouth-to-mouth resuscitation). In his statement and again in interview, the senior officer said that he formed the impression that the man was already dead. But he continued to attempt resuscitation whilst waiting for medical help. He continued to perform chest compressions, but his colleague was becoming increasingly distressed and so he told her to stop mouth-to-mouth.

93. A nurse was the member of healthcare staff on duty that day with responsibility for emergency response. When she heard the general alarm on the radio, she picked up the emergency response "grab bag" and made her way to the man's cell. (The "grab bag" contains medical equipment to allow staff to treat most emergency situations. This includes a defibrillator in case of heart problems, an ambu-bag to assist patients having difficulty breathing and oxygen.) The senior officer was still performing chest compressions on the man, and he briefed the nurse about what had happened.

94. The nurse assessed the man, but was unable to detect any obvious signs of life. She applied the ambu-bag (an inflatable bag with a mouthpiece, used to force oxygen into the lungs). She applied the defibrillator (a machine applied to a patient's chest via pads, which advises the user whether the patient has any heart activity that might respond to stimulus. If so, the machine can apply electrical impulses to the heart in order to reintroduce a normal rhythm). The defibrillator did not detect any rhythm from the man's heart.

95. When the emergency had been called, an ambulance had been summoned. By this time a healthcare officer had arrived in the cell, and she, the nurse and the senior officer continued to perform CPR until paramedics arrived.

96. The paramedics reached the cell at 2.08pm. The nurse briefed them on what had happened and the medical treatment given. The paramedics took over from the prison staff. They were unable to detect any signs of life and, at 2.18pm, the paramedics pronounced that the man had died.

97. An apparent suicide note was later found in the man's cell, which was handed to the police. The man expressed feelings of hopelessness, and that he was not receiving help that he needed. He said that he was unable to put across how he was feeling.

98. A debrief was held that afternoon. (Hot debriefs are held as soon as possible on the same day after a death in custody. They are held to ensure that staff involved have an opportunity to discuss any issues arising). It was made clear that support was available to staff, both at the time and subsequently.

99. Prisoners were informed of what had happened that afternoon. Listeners were brought onto the wing to provide support if required. All the prisoners who were subject to ACCT support had their cases reviewed within 24 hours

100. A memorial service was held in the prison chapel on Thursday 8 April.

Informing the family

101. Due to the distance between Swaleside and the home of the man's sister, his listed next of kin, news of his death was relayed to them by Greater Manchester Police in the early evening of the day of the man's death. They passed on contact details for the family liaison officer at Swaleside. Little more detail was available. The man's brother-in-law telephoned the number, but there was no answer and he tried again via the prison's main switchboard. The operator appeared to be unaware that there had been a death in the prison, but eventually the man's brother-in-law managed to speak to the family liaison officer at Swaleside.

102. The family liaison officer expressed his sympathy on behalf of the prison, passed on the information which was available and explained the family liaison officer role. The following day, the man's niece telephoned the family liaison officer. She explained that she worked for the Prison Service and, at her mother's request, would act as the single point of contact for the family. She asked some questions, some of which the family liaison officer was able to explain and others which he could not answer. He said that he was on leave for the following week, but that as it was a Bank Holiday weekend (it was Easter Sunday), he thought that the Coroner's proceedings would be unlikely to progress much whilst he was away. The man's niece asked for an alternative contact, but told the investigator that the family liaison officer was unable to name another person who would know about her uncle's death.

103. The man's niece contacted the prison again on 6 April to ask for further information. She spoke to the family liaison officer, but he was shortly due to leave the prison and so he gave her contact details to the duty governor. The duty governor was dealing with adjudications at the time, but he put them on hold in order to speak to her. He answered her questions as best he could, explaining that although it was the Coroner's decision to release the suicide note which the man had left, he was able to tell her some of the details. The man's niece asked if the chaplain would contact her mother, which he did the following day.

104. The family liaison officer returned from leave on 11 April and, on either that day or the following day, (the prison and family liaison logs differ) he took another call from the man's niece. She had a number of additional questions but, as the family liaison officer had just returned from annual leave, he was unable to answer them all at that time. The relationship between the two was becoming strained, and the man's niece felt that it might be helpful to have a different point of liaison. The family liaison officer spoke to a senior officer and asked if he might be able to help reduce the tension.

105. Over the following days, there were further telephone calls between the man's niece and the family liaison officer. Again there was some tension, the man's niece feeling that she was not given all the information which she asked for, and the family liaison officer having difficulty communicating why he was unable to provide all the information which she wanted.

106. In view of the problems which seemed to exist between the man's family and the prison, the governor telephoned the man's niece on 15 April. He explained that he wanted to make sure that communication improved, and asked her what the family wanted. There had been a breakdown in communication over the prison writing to the man's sister. When the man's niece had said that she wanted to be the single point of contact, the prison understood that to mean that she did not want anyone to write to her mother. However, this had not been her intention. The governor asked her to set out what the family wanted in an email, which she subsequently did.

107. The following day, 16 April, was the day of the man's funeral. The governor telephoned the man's niece in order to address the issues contained in her email. She pointed out that it was the day of the funeral and asked if this could be addressed at another time.

108. Over the following days there was further contact between the prison and the family. The relationship was close to breaking down, and the contact remained difficult for both parties. This extended to communications over the return of the man's property. The family thought that they had made it clear that they would prefer a courier service to be used, but the prison thought it more personal for a member of staff to take the property to the man's sister's home. This meant that she had to check and sign for the property, which she felt unable to do at the time.

Post mortem

109. A post mortem examination was carried out on 7 April at outside hospital. The post mortem report gave the cause of the man's death as "suspension".

ISSUES

Preparation for the man's case to be referred to the Parole Board

110. When they considered the man's case in 2007, the Parole Board asked to consider him again after another two years, to allow him to undertake identified work. However in August 2009 the psychology department refused to contribute to his parole dossier on the grounds that the targets had not been completed. They pointed out that the psychology department at Swaleside did not have the capacity to complete the work which the Parole Board had recommended. The Board had also recommended that he should undertake a cognitive skills booster course, and the papers do not make it clear whether the man actually did so.

111. I find this very troubling. While the clinical reviewer points out that the man seems to have been offered support within a care plan, an intervention had been specifically identified as necessary by the Parole Board but had not taken place. It appears to be bad planning to have sent the man to a prison where that specified intervention is not available. His family said that his powerlessness to engage with the mental health services was a source of frustration for the man. Bearing in mind the obstacle this would place to him progressing with his sentence, I think that this is understandable.

112. Once the psychology department declined to provide a report for the Parole Board, the man's consideration for a place at the hospital for the treatment of prisoners with mental health needs seems to have been taken forward properly. The clinical reviewer says that arrangements for his referral to the hospital seem entirely appropriate, and that the prison psychiatrist provided a clear and detailed referral letter to the unit.

113. However, once prisoners have been compulsorily admitted under the Mental Health Act (which was necessary to allow the man to go to hospital), their parole applications are suspended. The man had arrived in Swaleside in January 2009, with his case due to be referred back to the Parole Board the following December. There was an outstanding recommendation from the Parole Board for psychological intervention, but this did not begin until he transferred to the hospital for the treatment of prisoners with mental health needs in December, the month the Board were due to consider his case. So his referral to the Board was suspended at the point that it should have happened, despite him being in Swaleside for almost a year by that point. I regard this delay as unacceptable.

114. The man's family said that it seemed to them that the move to the hospital had suited him well. He appeared happier and more confident. As well as psychiatric support and intervention, the hospital offered a wide variety of activities, which included allowing him to exercise his talent for art. But he expressed concern that the parole process was on hold, and his family thought this might have been the reason he decided to leave the hospital and return to prison.

115. The man was undoubtedly concerned about his future. He complained of difficulty engaging with the Probation Service to plan towards his eventual release. His family confirmed that this caused the man some concern. I think that such engagement should be part of sentence planning.

116. After his transfer back to Swaleside, the man does not appear to have had any contact with the psychology department. His return from hospital back to prison was an opportunity for his sentence plan to be re-evaluated. However, this does not seem to have happened. Accepting the fact that the man had trouble in engaging at the hospital, the Prison Service should nevertheless have ensured that outstanding Parole Board recommendations could be addressed. Instead he was returned to Swaleside, where the necessary psychiatric input was not available.

117. The lack of clear goals was one of the issues identified as a problem for the man in his ACCT plans. At the review on 20 March it was agreed that the Regimes Department were to assess targets for him as he felt that he had nothing to aim for. The papers do not, however, show that this was taken forward.

118. It seems that the man did not have the benefit of any plans to take him forward through his sentence. His family told my investigator that for some years he had been unhappy about what he perceived as lack of engagement with the Probation Service. He was sent to Swaleside with an outstanding recommendation from the Parole Board, but the prison did not have the facility to address it. He did not transfer to the hospital for the treatment of prisoners with mental health needs to begin his treatment until the Board were already due to consider his case again. I do not think it is acceptable that such difficulties should only come to light when the problem had already occurred. I recommend that the Governor ensures that prisoners' sentence progression needs are assessed on arrival in the prison, to ensure that any anomalies are addressed without delay.

The National Offender Management Service should consider how to ensure that, when interventions are identified for prisoners, they are allocated to establishments able to deliver them.

The Governor should ensure that effective sentence plans are considered for all prisoners on arrival, ensuring that any outstanding work or intervention is planned and provided for.

Outstanding medical appointments

119. On his return from the hospital, the man had two outstanding medical appointments, with the ophthalmologist and neurologist. It does not appear that they were followed up. Medical appointments are an important aspect of providing continuity of care and it is vital to the health and wellbeing of prisoners that such appointments are followed up by the receiving prison.

The Head of Healthcare should ensure that effective systems are in place to identify and act upon any outstanding medical appointments for incoming prisoners.

Personal officer scheme

120. The man was allocated a personal officer. However, his personal officer was not formally notified that the man had been allocated to him, and only noticed when the man's name appeared on his electronic list. He had not received any training in what a personal officer's duties included. Although he was aware that the man was subject to ACCT support, he did not have a great deal of interaction with him.

121. At the ACCT review on 27 March it was agreed that the man's personal officer would assist in a transfer application as well as helping him to apply for accumulated visits. But it does not appear that this was taken forward, and it is not clear whether the request was passed on to the man's personal officer.

122. If the man had a stronger relationship with his personal officer, it might have provided an opportunity for him to raise any of the issues that were troubling him, such as concern over his lack of contact with mental health services or delays with his case being put to the Parole Board. It is not possible to say whether this would have had any affect on the tragic outcome, but the Governor should assess the operation of the personal officer scheme and satisfy himself that it is operating to an acceptable standard.

The Governor should consider the operation of the personal officer scheme in Swaleside, and whether prisoners are receiving adequate support from their personal officers.

Managing the man's ACCT support

123. When a management check was conducted on the man's ACCT plan on 27 March, it was noted that the trigger warnings were not noted at the front of the form. It was also noted that the man himself had not signed the caremap. In general, the observations on him were within the correct time limits. Sometimes his observations were made slightly beyond the hour. Although this was usually by less than 15 minutes, there were occasions when an observation appears to have been missed out or when there was more than an hour between checks. Broadly speaking the observations were regular and frequent, and in the hours before the man died were carried out correctly so that any deficiencies are unlikely to have made any difference to the outcome. But the Governor may wish to remind staff of the importance of carrying out ACCT supervision as directed.

124. On 19 March, the man told a member of staff that he had not collected his medication for two days. Even though arrangements were made to overcome the reasons for this, he again did not collect his medication on 21 March. This was not noted until the following day. I suggest that a prisoner on an ACCT plan who misses their anti-depression medication should be considered at

heightened risk and this should have been noted immediately. The Head of Healthcare may wish to consider whether there are adequate measures in place to monitor the distribution of medication to prisoners receiving ACCT support.

The Head of Healthcare should consider whether there are adequate measures in place to monitor the distribution of medication to prisoners receiving ACCT support.

Unlocking the man's cell door

125. There are inherent difficulties in trying to establish a true timeline for emergency situations. Witnesses do not automatically note the time they saw things or what others were doing when they themselves reacted. The times given for events from witness statements do contradict each other, and in drawing conclusions as to timings it is necessary to consider all the evidence and judge the most probable sequence. It seems likely to me that, when the man's cell door was unlocked at 1.45pm on the day of his death, he was already dead. The last time he had been seen alive was the ACCT check at 12.58pm. We have no certain evidence of exactly how long it was between the man being unlocked and being found. Staff who attempted to revive him minutes after he was found could not detect any signs of life, although they rightly continued with attempts to revive him until paramedics took over. I note that the man's family are of the opinion that as the time lapse between him being unlocked and him being found is uncertain, no conclusion as to whether he was alive when unlocked can be drawn.

126. An officer was responsible for unlocking the cells on the wing which included the man's cell. Bearing in mind that the man was subject to ACCT support at the time, my investigator questioned the officer about unlocking the man and the check she made through the observation hatch on doing so. She explained her understanding of the check as threefold. Firstly, to confirm the prisoner's position to ensure the officer's own safety when the door is unlocked. Secondly, to ensure that the prisoner is physically present in the cell and has not escaped. Thirdly, as far as possible, to ensure the prisoner's wellbeing.

127. The officer told the investigator that she remembered checking on the man and knew that he was subject to ACCT monitoring. When she looked through the observation hatch, she saw him apparently standing facing her, looking at the observation panel. This is something many prisoners do when they hear other cells being unlocked, anticipating their own unlock. The man's cell was towards the end of his wing, and was one of the last to be unlocked. The officer realised with hindsight that, when she looked in on the man, he must have been hanging. But at the time, with the position of his body and the way he had secured the ligature around his neck and behind his head, it simply appeared that he was standing facing the door.

128. I have given this issue close consideration. The officer was aware that the man was subject to ACCT support. I would usually expect a member of staff

unlocking a prisoner on an ACCT plan to gain a response from them to ensure that there were no problems. The officer believed that the man was standing in his cell facing her and waiting for her to unlock his door. As it was common for prisoners to stand facing the door when they heard others being unlocked, it therefore appeared to her that he was alright. In the event, the officer was sadly mistaken.

129. The man was subject to ACCT support. He had made attempts to take his own life on previous occasions through his sentence. At least some of his attempts appeared to be less than a serious attempt to kill himself and more of an expression of needing help and support. On this last occasion, the man may have hanged himself facing his cell door so that he could easily be seen and rescued. He was due to have his ACCT review that afternoon and may have wanted those at the meeting to be aware of how he was feeling, although of course we have no way of knowing his thoughts or intentions. I am aware that his family do not believe that the note found in his cell read as a suicide note, and believe it likely that the man wanted to be found and did not intend to take his own life.

130. While I accept that the officer did check on the man and genuinely believed that he was alright, he was a man with a history of suicide attempts who was subject to ACCT monitoring. I recommend that the Governor remind all staff of the importance of being extra vigilant when dealing with prisoners on ACCT support.

The Governor should remind staff of the importance of extra vigilance when unlocking prisoners who are subject to ACCT support.

Response to the man being found

131. Once staff were alerted to the fact that the man was hanging, the response seems to have been swift. Two officers cut the ligature, lowered him down and called for help. One of the officers put the man into the recovery position. If he was not breathing, putting him in the recovery position would not have provided any benefit. The officer received some first aid training as part of her initial training on joining the service, but none since. Prison Service Order (PSO) 2700 contains guidance to staff on actions to be taken when discovering a prisoner hanging. In Annex 13A the PSO says that after cutting the ligature and lowering the prisoner, staff should:

> " … 3. Place the prisoner on his/her back on a flat, solid surface.
> 4. Check for signs of life, i.e. breathing, pulse, any movement of the body
> 5. If not breathing and/or no pulse is present, clear airway and attempt resuscitation, using a face mask with non-return valve, unless rigor mortis of the limbs has clearly set in."

132. As mentioned above, it is likely that the man had died by this point. Nonetheless, the Governor should remind staff of the guidance.

The Governor should remind staff of the guidance contained in PSO 2700 of the actions to be taken when a prisoner is found hanging.

133. A senior officer arrived at the cell very soon afterwards, and began to perform CPR whilst instructing the officer to assist by performing mouth-to-mouth resuscitation. The senior officer thought that the man was already dead, but rightly continued to attempt resuscitation whilst waiting for medical help. But the officer was becoming increasingly distressed, so he instructed her to stop. I have to consider whether, in the circumstances, the senior officer was right to do so. PSO 2700 gives the policy on resuscitation and says:

> "**Resuscitation**: Policy remains that staff should continue to attempt resuscitation – as appropriate to the injury – until told to stop by a healthcare professional, e.g. a member of the Ambulance Service or a doctor, or rigor mortis has clearly set in …"

134. Even though he thought that the man was dead, the senior officer continued to attempt resuscitation until (and beyond) the arrival of a nurse. He also had a duty to his staff, and his colleague was clearly becoming upset. It is unlikely that it made any difference to the outcome for the man.

135. In the circumstances I do not think it is fair to criticize the senior officer, who reacted efficiently and professionally in a very difficult situation. The clinical reviewer agrees, and notes that the officer had already given some rescue breaths before she stopped. That, followed by chest compressions, still constitutes good resuscitation technique. But the officer's reaction may have been exacerbated by performing mouth-to-mouth resuscitation without a mouth shield. I understand that all staff in Swaleside now carry mouth shields in case they need to perform resuscitation. I welcome this news, and ask the Governor to remind staff of the importance of carrying them.

136. A nurse arrived at the cell soon after the senior officer, followed by a healthcare officer. The man received full medical assistance until the paramedics confirmed that he had died. The clinical reviewer recommends that staff rotas should include staff who have had recent first aid training, but says that the resuscitation attempts on the man were "exemplary".

137. I think it is important to mention the view of the man's friend in relation to the response when he was found. His friend was across the landing from the man's cell at the time. He told my investigator that in trying to revive him, staff "couldn't have done more" for his friend. I hope that this provides some degree of comfort for the man's family.

Family liaison

138. It is clear there were problems in family liaison in this case. The family liaison officer in this case was Swaleside's only trained family liaison officer at the time. When the man died, the family liaison officer was actually on leave but came back to work to perform these duties, which in itself is commendable. But his leave was due to continue through the following week. This meant

that the family did not have a contact in the prison in the days following the man's death, a time when most families benefit from having someone who is knowledgeable and able to help and support them through what is an unfamiliar process at such a distressing time.

139. On the family liaison officer's return from leave, there were further problems in relations between the prison and the family. Both the family and the prison provided contact logs to my investigator. Eventually, in response to a request by the family, it was agreed that a different point of contact should be provided. But it seems that by then the relationship was already on the verge of breaking down. The family said that they felt significantly distressed by the liaison with the prison which, in turn, undermined their confidence both with regard to the care which the man received and the information they were given regarding the circumstances of his death.

140. Liaising with the family of a prisoner who has taken their own life is a very difficult task, for which prison staff receive special training. Families react in different ways and have different needs regarding their interaction with the prison. This must be recognised and given due weight. In this instance, the liaison may have initially appeared to be more complicated because the man's niece was a Prison Service colleague. This should not, though, be perceived as the family needing any more or less sensitivity than any other bereaved family.

141. It is important to remember that, first and foremost, the man's niece was a bereaved relative. The prison as a whole, not just the family liaison officer, must be sensitive to the family's needs. If there are problems in the relationship with the person acting as liaison officer, then they should be addressed as a matter of priority. This is not apportioning blame to the officer concerned, but ensuring that families are supported through a difficult time in a way that is sensitive to their individual needs and circumstances. In this case, the prison's reluctance to review their existing arrangements, which they felt had worked well in the past, caused the man's family considerable distress.

142. I understand that two Swaleside staff members are currently being trained in family liaison duties and I welcome this news. The Governor will wish to ensure that future family liaison arrangements have in-built processes to monitor the contact and ensure that any problems are identified and addressed at an early stage.

The Governor should ensure that, if the nominated family liaison officer is unavailable, an alternative should be provided.

The Governor should satisfy himself that the family liaison arrangements ensure that any problems in relation to bereaved families are identified and addressed at an early stage.

CONCLUSION

143. The man had been in prison for a number of years. He had progressed as far as open prison on three separate occasions, but had been unable to cope with the regime and had ended up back in a closed prison. He had some anxiety about how he could progress towards release.

144. When the Parole Board last considered his case, they recommended that some intensive psychological work was undertaken before they next saw his papers. There were important issues for the man that needed to be addressed. But the man was not given the chance to undertake the work identified until the time that his case was due to be referred to the Parole Board. He was transferred to a specialist unit, and his referral to the Board was adjourned while he was there. He failed to settle, possibly because of the delay to his Parole Board application, and returned to prison.

145. Once back in prison, the man's Parole Board application was restarted. He was, though, rather despondent about his prospects. He seems to have taken some drugs that were not prescribed to him, and got into debt with other prisoners. He was subject to special monitoring for those thought to be at risk of harming themselves, something he had done a number of times previously.

146. Nevertheless, those around him thought that he seemed to be developing a more positive attitude. He remained on special monitoring, but there were no significant concerns that he would imminently harm himself.

147. During the lunch period on the day of his death, the man made a ligature from bedclothes and hanged himself in his cell. When the cell door was unlocked, the officer responsible did not notice what the man had done. But almost immediately some prisoners went into his cell, and raised the alarm. Staff responded and provided first aid until an ambulance arrived, but attempts at resuscitation were unsuccessful.

148. The man's family were informed, but relations between them and the prison quickly deteriorated. Eventually the prison changed the main liaison officer, but by this time the relationship was close to breaking down.

149. I make nine recommendations. The first is a national recommendation concerning prisoners being sent to prisons where they can achieve their sentence planning goals. My other recommendations relate to prisoner allocation, outstanding medical appointments, the personal officer scheme, monitoring prisoners who are at risk of harming themselves and the actions to be taken when someone is found hanging. I also comment on the apparent breakdown in the relationship between the bereaved family and the liaison officer, suggesting that it should have been addressed earlier.

RECOMMENDATIONS

1. The National Offender Management Service should consider how to ensure that, when interventions are identified for prisoners, they are allocated to establishments able to deliver them.

   This recommendation was partially accepted. Responses were received from Swaleside, Rehabilitation Services in the National Offender Management Service, and the Population Management Unit of the National Offender Management Service.

   Swaleside said:

   "[The man] was sectioned under the mental health act, from HMP Swaleside, as that was the best course of action to manage his circumstances at that time. If an individual is later returned to custody, they are usually returned to the sending establishment. The offender's OASys will then be reviewed and consideration would be given to the SPRM and the most appropriate establishment to deliver the interventions.

   Unfortunately there are often large demands for courses at all establishments, and as the demand for courses change, what each establishment delivers changes too and this has to be reflected in offenders' sentence plans. This is not an issue resolvable at establishment level, the Governing Governor will write to the DDC asking him to raise with the NOMS board the need for transfers to be influenced by Sentence Planning needs."

   NOMS Rehabilitation Services said:

   "I have looked at the relevant recommendation from the PPO report as requested from the RSG perspective and our view is that this is a local rather than a central matter.

   Centrally, we have issued guidance on sentence planning and on the suitability of accredited interventions for offenders. However the management of individual offender's access to and attendance on programmes is a local matter.

   It is for offender management and population management teams locally to make the necessary arrangements to enable access to interventions required, including the arrangements to facilitate transfers where necessary.

   I understand that guidance re: the transfer of prisons has also been issued centrally by population management."

   NOMS Population Management Unit said:

   "Population Management Unit receive several hundred individual transfer requests (singleton transfers) on a weekly basis; these can be moves for a plethora of reasons which would include (but is not exclusive to), further court appearances, discipline moves due to segregation, progressive move due to recategorisation, progressive/onward allocation for courses/interventions.

At the time of [the man's] death, PMU held a database for the allocation of life sentence prisoners, this database was apparent as most/all establishments in the training estate operated a limit (or operational cap) for the number of lifers they could hold. It is realistic to say that all establishments were operating at their prescribed limit, and would accept transfers on a 'one out, one in basis'. The consequence of this is that the process was slow, and progress for lifers was delayed.

In July last year, PSI (Prison Service Instruction) 36/10 Chapter 4 life sentence prisoners was introduced, it instructed the removal of caps for ISP (Indeterminate Sentence Prisoners) prisoners at prisons, and stated that the onward allocation for ISP prisoners should not differentiate from that of determinate sentence prisoners.

PMU rely on sending/receiving establishments to agree the transfer of prisoners, including for those moving for interventions, PMU do not broker any transfers, we facilitate the logistics, and avail the space(s) at the prison allocated to. It is for the prisons to highlight how much of a priority every move is, thus making PMU aware (depending on the availability of space) whether the move needs to be expedited. We receive approximately 400 single transfer requests a week, of which around 150 are actioned; this figure takes into account the contractor's resource availability, and also space availability at receiving prisons."

2. The Governor should ensure that effective sentence plans are considered for all prisoners on arrival, ensuring that any outstanding work or intervention is planned and provided for.

This recommendation was accepted. NOMS said:

"We are currently exploring how we link up Sentence Planning, Activities and Induction, to ensure that Offenders are given a seamless experience in HMP Swaleside. It needs to be noted that this has only recently returned to full control of the governor of HMP Swaleside, and he has already appointed a Head of Sentence Management to address this issue.

It is entirely feasible that had this been in place, we may have identified that [the man] needed to be moved to another site to continue his progressive work, however it is unlikely in the short time frame between returning from secure unit, that [the man] would have gained a transfer given the acute population pressure we were facing at that time."

3. The Head of Healthcare should ensure that effective systems are in place to identify and act upon any outstanding medical appointments for incoming prisoners.

This recommendation has been accepted. NOMS said:

"This is part of the existing healthcare reception process. Outstanding appointments are flagged and actioned."

4. The Governor should consider the operation of the personal officer scheme in Swaleside, and whether prisoners are receiving adequate support from their personal officers.

This recommendation was accepted. NOMS said:

"The Governor and SMT (Senior Management Team) are currently reviewing the Personal Officer Scheme. Early thinking is that the title Personal Officer will be re-badged Line Manager. The prisoner's Line Manager will become more involved in sentence management with an emphasis of assisting prisoners who require additional support to make them better citizens and reduce their risks to the public. Prisoner Consultative Meetings have agreed this way forward."

5. The Head of Healthcare should consider whether there are adequate measures in place to monitor the distribution of medication to prisoners subject to ACCT procedures.

This recommendation was accepted. NOMS said:

"Primary Mental Health Manager will ensure that those prisoners who are assessed as being at risk of self harm are routinely reviewed for concordance with their medication. A Healthcare Notice to Staff (will be issued)."

6. The Governor should remind staff of the importance of extra vigilance when unlocking prisoners subject to ACCT procedures.

NOMS accepted this recommendation. They commented:

"The Safer Custody Manager will prepare a written Notice to Staff, additionally briefing will be given by Wing Managers to their staff reminding them of the importance of extra vigilance when unlocking prisoners who are subject to ACCT procedures."

7. The Governor should remind staff of the guidance contained in PSO 2700 of the actions to be taken on finding a prisoner is found hanging.

NOMS accepted this recommendation. They said:

"The Safer Custody Manager will show a DVD demonstrating the correct course of action at the next full staff meeting. A Notice to Staff giving precise instructions will also be issued."

8. The Governor should ensure that, if the nominated family liaison officer is unavailable, an alternative should be provided.

This recommendation was accepted. NOMS commented:

"At the moment Swaleside have one fully trained FLO. Two additional managers have been identified for training and their learning paths have been updated. If the trained FLO is unavailable the Governor has an agreement with the Sheppey Prisons' Group that a FLO from Elmley, Standford Hill or Central Services will be made available."

9. The Governor should satisfy himself that family liaison arrangements ensure that any problems in relation to bereaved families are identified and addressed at an early stage.

This recommendation was accepted. NOMS said:

“FLO will be briefed by the Head of Residence to ensure that the families are contacted in the first instance and that problems are addressed as soon as possible at the earliest possible opportunity.”