The circumstances surrounding the death of a man at HM Prison Preston in May 2006

Report by the Prisons and Probation Ombudsman for England and Wales

February 2007

This is the report of an investigation into the circumstances surrounding the death of a man at HM Prison Preston. The man was found hanging in his cell at 6.20pm on Friday 19 May 2006 and was pronounced dead at 6:45pm. He was 38 years old.

I offer my sincere sympathy and condolences to the man's family and friends for their tragic loss. Concerns expressed by his family about the reasons for her brother's imprisonment and recall have been addressed in this report.

The investigation was carried out by my colleague. I also commissioned an independent clinical review of the management of the man's healthcare needs while he was in custody. This was conducted by a representative of the Rochdale Primary Care Trust.

I judge that the man was properly cared for while in custody, and that his death could not have been predicted or directly prevented. Nevertheless, I hope that the recommendations I make in this report, together with those I have made in reports of other investigations into deaths at Preston, will help to prevent further tragedies.

Stephen Shaw CBE **February 2007**
Prisons and Probation Ombudsman

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SUMMARY

On 29 July 2005, the man appeared in court charged with a number of offences under the Protection of Children Act 1978. He was found guilty on all counts and was sentenced to a 39 month extended prison sentence. This comprised a custodial period of three months to be followed by a period of three years under supervision in the community. The extended sentence was due to expire in October 2008. The man was taken to Preston prison that evening.

As part of the reception process, the man underwent a health screen during which he admitted to taking an overdose of tablets three months earlier and to suffering from depression. A Probation Officer at the prison faxed to the reception staff an extract from the man's pre-sentence report in which a concern had been expressed that he presented a risk of self-harm or suicide upon imprisonment. As a consequence, although the man was not assessed as being actively suicidal, he was immediately made subject to self-harm monitoring procedures. After closer assessment, these were terminated the following day. The man was allocated to a shared cell in the establishment's first night centre and induction unit. He remained in the unit for a week.

On 4 August, the man's mother died of cancer. Initially, he coped well with this news which he had been expecting. He made it clear to staff that he did not wish to attend the funeral because he did not want his father to know that he was in prison.

On 8 August, the man was transferred to Wymott prison. Upon his arrival, he was placed on self-harm monitoring procedures. These were terminated on 11 August. It appears that the self-harm monitoring form (F2052SH) was lost after his departure from Wymott.

On 6 September, the man was released from Wymott on a parole licence to a Probation Service Approved Premises, where he was required by his licence conditions to reside under supervision by the Probation Service until the expiry of his sentence. However, as a result of his unacceptable behaviour in the hostel, he was recalled to prison on 21 March 2006. He was returned to HMP Preston the next day.

Back in prison, the man underwent a further reception health screen. He told the nurse who completed the screen that he did not feel suicidal. He was assessed as fit for normal location (i.e. to be allocated to a wing), but was referred to a doctor so that he could be prescribed appropriate medication for his depression.

Thereafter, the man remained at Preston. He received no visits while he was there. Between 23 March and 19 May, very little information was recorded in his wing history sheet about his demeanour. On 27 March, he started work as a healthcare centre cleaner, a job which allowed him some autonomy and which got him out of his wing for most of the working day. However, on 15

May, he was dismissed from that job after he had used a photocopying machine.

On the same day, the Parole Board met to consider whether to uphold the decision to recall the man to prison. The panel decided that the decision was appropriate and concluded that, until further work had been undertaken on risk factors identified by his supervising officer, the man posed an unacceptable risk for re-release. A member of the Probation Team at Preston wrote a letter to him on 18 May, informing him of the Parole Board's decision and warning him that he might have to remain in prison until the expiry of his sentence in October 2008. The Probation Officer who wrote the letter was certain that he did not receive it before he died.

At 6:15pm the next day, the man was found hanging in his cell by a wing orderly. All attempts by Prison Service staff, nurses and paramedics to revive him failed. He was pronounced dead at 6:46pm.

The clinical review concludes that the management of the man's mental health needs was adequate. I agree with that conclusion, although I have drawn attention to the need for improvements in the manner in which the mental health needs of released prisoners are communicated to outside agencies. I also conclude that the management of the man's risk of self-harm and suicide was appropriate.

I make five recommendations and three commendations to the Governor of Preston and three further recommendations to the Governor of Wymott.

INVESTIGATION PROCESS

The investigation was conducted by my colleague. It was formally opened on 26 May when my investigator briefed the Governor, a representative of the Independent Monitoring Board and a representative of the Prison Officers' Association on the terms of reference. On the same day, notices were issued to staff and to prisoners announcing the investigation and encouraging those who wished to offer information about the man's death to make themselves known.

An independent clinical review of the management of the man's healthcare needs while he was in custody was undertaken by a representative of the Rochdale Primary Care Trust.

A number of staff and prisoners were interviewed during the course of the investigation.

In July 2006, one of my Family Liaison Officers made contact with the man's next of kin who asked for clarification of the reasons for his being recalled to prison. These are provided later in this report.

HM PRISON PRESTON

Preston prison is a large Victorian building situated near the town centre. It has operated as a local prison since 1990, serving Magistrates' and Crown Courts in Lancashire and Cumbria.

At the time of the investigation, the establishment held up to 619 male adult remand and convicted prisoners. Its accommodation comprises six wings, a segregation unit and a healthcare centre. The latter provides inpatient facilities for up to 30 prisoners on two floors: 22 beds on H1 landing are available for those with mental health problems and the remaining eight on H2 landing are for patients with general medical ailments.

Healthcare at Preston is delivered by the Preston Primary Care Trust (PCT). At the time of the investigation, eight Healthcare Officers were still employed by the Prison Service, while the remainder were employees of the Preston PCT. Nursing cover is provided 24 hours a day.

Preston was last inspected by Her Majesty's Chief Inspector of Prisons in 2004. The report of that inspection commented that good systems were in place to help those prisoners considered to be at risk of self-harm or suicide, although they were limited by not being part of a broader safer custody approach to managing prisoners' safety. This investigation found evidence of improvements in that area of the establishment's work.

Between April 2004 and May 2006, six prisoners have died at Preston, three of whom apparently died from natural causes. The other three, including this man, died apparently by their own hand.

KEY EVENTS

Preston: 29 July -8 August 2005

In July 2005, the man appeared in court charged with a number of offences under the Protection of Children Act 1978. He was given a 39 month extended prison sentence. This required him to undergo an initial three month period in custody and, thereafter, to be supervised in the community for three years. He was eligible to be released from the initial custodial period in September 2005.

After his court appearance, the man was taken to Preston prison. The Prisoner Escort Record (PER), completed by the staff who escorted him to the prison, recorded no concerns regarding self-harm or mental illness.

However, a seconded Probation Officer at the prison sent an urgent fax to the reception staff drawing their attention to the concern that had been expressed in the man's pre-sentence report about his risk of self-harm:

> "I believe there to be a clear risk of self-harm in this case: the defendant informed me that, as a direct consequence of these proceedings, he recently took an overdose of antidepressant medication together with alcohol, with the intention of ending his life. His family does not know about this case, and he was clearly distressed in interview when he considered the prospect of their finding out, particularly as his mother is extremely ill with cancer and has, I understand, a poor prognosis. Should the defendant receive a custodial sentence, it would, therefore, have a considerable impact on his family, as he is currently helping to care for his mother. In the event of such a sentence, his mental health and emotional state would require, in my view, constant and close monitoring."

The nurse who was on duty in reception when the man arrived, read the fax as soon as it was received. Although she saw no direct evidence that he was depressed, emotional, preoccupied or suicidal at the time, she nevertheless decided to open an ACCT (Assessment, Care in Custody and Teamwork) form, in view of the concerns expressed in the pre-sentence report and because the man told her that he had taken an overdose of paracetamol three months earlier. The immediate action plan was for the man to be located in a shared cell. He was to be checked that night on an hourly basis and, during the following day, once in the morning, once in the afternoon and once in the evening. A note was also made in the immediate action plan that, as a former Listener (a prisoner trained by the Samaritans to help other prisoners in distress), the man would be aware of the support he could be given. It was further noted that he was to be given any phone calls he needed. The action plan was signed by a Unit Manager at 7.30pm on 29 July.

The nurse also completed an initial health screen on the man. She noted that his physical health was marred by a shoulder injury he had sustained in an accident some years earlier and that he suffered from allergies. The nurse also recorded that the man admitted to drinking alcohol on an occasional basis. As far as his mental health was concerned, she noted that he suffered from depression and was currently taking anti-depressants. Although the man volunteered that he had taken an overdose of tablets two to three months earlier, he told the nurse that he was not currently feeling suicidal despite being in prison. He did not wish to see a doctor. At interview, the nurse confirmed that instead of ticking the box on the health screen proforma to show that she had opened an ACCT form, she incorrectly ticked the box to show that she had referred the man for a mental health assessment.

A cell-sharing risk assessment was also carried out that day. This said that the man presented a low risk of harming others. He was therefore allocated to the induction unit and placed in a shared cell.

On 30 July, the nurse saw the man again, this time in the Induction Unit where she carried out a Well-man assessment. At interview, the nurse said that this assessment equated to a secondary health screen. She was satisfied that, although the man was already taking medication for depression, he had no thoughts of suicide, had no sleeping problems, and was not worried about anything. Thereafter, the nurse had no further formal contact with the man, although on occasions she met him in the healthcare centre during his period of employment as a cleaner.

On the same day, the Safer Custody Officer carried out an ACCT assessment interview with the man. The officer recorded that the man was concerned that his mother was in hospital with cancer and that she was not expected to live very long. The man said he did not wish to tell her that he was in prison. He was also anxious about the nature of his offences and about the reaction he might get from other prisoners. He told the officer that he had taken an overdose in Wymott prison nine years earlier after being bullied. He also admitted to suffering from depression and told the officer that he was currently taking anti-depressant medication. He nevertheless said that he had no thoughts of harming himself and was quite relieved at being in prison "after all the anxiety and worry caused by the court appearances". The officer noted that, in his opinion, the man was coping very well in custody, but that a problem might arise if his mother were to die. The man told the officer that such an event would not lead to a self-harm attempt. The officer's concluding remarks were,

> "The man and I both agree that there was very little risk in him self-harming in the six weeks he has to serve. He was a Listener on his last sentence so he is fully aware of all the support available to him in prison and how to access this. In my opinion, this form can be closed at the earliest opportunity."

The officer signed the record of the ACCT assessment interview at 2.15pm on 30 July.

The ACCT assessment interview was followed by an ACCT case review, chaired at 2.20pm by a Senior Officer. Present at the review were the Chaplain, the Safer Custody Officer and the man. The review was summarised as follows:

> "No thoughts of self-harm.
> Ex Listener previous sentence.
> He is well aware of support in custody.
> All personnel in agreement that this document should be closed."

The ACCT form was closed and a follow-up interview was set for 9 August. However, this was overtaken by events. By that date, the man had been transferred to Wymott where a F2052SH was opened the day after his arrival.

On 30 and 31 July, an Observation Classification and Allocation assessment was completed by an officer and a Senior Officer. The man was made a category C prisoner and was earmarked for allocation to Wymott prison, also in Lancashire.

On 4 August, a member of the chaplaincy team at Preston received a telephone call from a staff nurse at a hospital on Merseyside to say that the man's mother had died at ten minutes past midnight that day. The man's sister and her father were at the mother's bedside when she died. The man was told of his mother's death at about 10am. Although he seemed to take the news relatively well, he said he did not wish to attend the funeral because he did not want his father to know he was in prison.

On the same day, the man was seen by a prison doctor, who made the following entry in his medical record:

> "1. H/o depression and is already on dothiepin. Mother died yesterday. Has only known she was terminal for few days. Father devastated. Doesn't know son is in prison. Says news hasn't hit him yet but feels he will need something more to help him. Dothiepin not especially good + gives him stomach pains. Change to Venlafaxine 37.5mg bd. Zopiclone 7.5mg nocte for 5 nights.
>
> 2. Severe L shoulder injury a few months ago-crushed. Still in pain. On examination: tender upper rotator cuff and cupraspiratus. Limited obduction. Pain on rotation. On waiting list for physiotherapy. Co-codamol 30/500……"

Wymott: 8 August - 6 September 2005

On 8 August 2005, the man was transferred to Wymott, arriving shortly after 11am. The Prisoner Escort Record (PER) completed for the journey contained no notations of any risk of self harm, although it did contain a reference to the man's vulnerabity because of the nature of his offences.

Upon his arrival at Wymott, the man underwent a further reception health screen completed by a nurse. The man told the nurse that he did not suffer from any heart problems, was not a diabetic, was not asthmatic or epileptic, and did not have any disabilities. He admitted to being a smoker and said he was allergic to penicillin and fish. He also said that he had not had any contact with psychiatric services and had not suffered from mental illness. He said he was currently suffering because of his mother's recent death and mentioned that he had taken an overdose in the weeks prior to being sentenced. As a result, the next day the man was made subject to self-harm monitoring procedures.

The nurse recorded that a self-harm monitoring form (F2052SH) had been opened (Wymott had not, at that time, introduced the ACCT form) and decided to refer the man to a doctor. He was allocated a cell on G Wing, the Induction Unit, where he remained until 22 August.

On 10 August, the following entry was made in the man's medical record at Wymott prison: (*the gaps represent words that are illegible)*

> "F2052SH opened 9/8/05.
> Stressed out.
> Mother died Thursday 4/8/05.
> On anti-depressants.
> Not coping.
> Nil suicidal. Nil ……
> Demanding of opiate medication for shoulder.
> Good behaviour. Speech normal. Nil psychosis.
> Imp 1. Depression +/- …….
>
> 2. Shoulder – very good …..
> seen at CDH -.> nil.
> Physio referral to be chased up
> On examination: L shoulder good…..
> Good …….
> Nil ……..
> Nil..tenderness
> Imp 1. ……..
>
> Plan: …….
> Change to……
> Remedial gym
> Chase up physio referral at CDH"

On 11 August, the following entry was made in the man's medical record:

> "Attended F2052SH review. Closed."

This was signed by a registered mental nurse.

The documents presented to my investigator at Preston did not include the F2052SH used at Wymott. My investigator was advised by the Suicide Prevention Co-ordinator at Wymott that the log of F2052SH documents that were still available confirmed that a F2052SH had indeed been opened for the man on 9 August, the day after he arrived. She also confirmed that the closed document should have been forwarded to Preston as soon as the man returned there in March 2006. She could not account for the absence of the document from the man's core record. The Suicide Prevention Coordinator asked her staff to search the archive room at Wymott. However, the F2052SH was not found.

On 22 August, having completed his period of induction, the man was transferred to a Vulnerable Prisoner Unit in A Wing. He remained in this unit until 6 September.

Probation Service Approved Premises: 6 September 2005 - 21 March 2006:

On 6 September 2005, the man was released on licence from Wymott. He was required to reside at a Probation Service Approved Premises (Probation Hostel). The man made his own way to the hostel that day.

There is no evidence in his medical record to show that he had been assessed as being fit for release from prison, or that his mental health needs had been communicated to any outside agencies so that appropriate support could be given. However, upon his arrival at the hostel, the man was seen by a Probation Officer who expressed no concerns about his mental well being, although she did suggest to him that he should participate in bereavement counselling. An initial appointment was made for the man to attend a counselling session on 15 September. He kept this appointment but decided that he did not need further support. The Probation Officer also referred him to another agency so that he could be given support to reduce his level of alcohol consumption. The man attended some of these sessions.

Whilst he was at the Approved Premises, the man also undertook what is known as a "Life Map". This is an exercise that aims to help people examine the events that have shaped their lives. The man's Life Map referred to many unhappy memories, particularly that of the death of his mother which he described as "the single most devastating event" of his life.

The man spent nearly seven months at the Approved Premises. My investigator was able to study a number of Probation Service reports about his behaviour and achievements at the hostel. These show that, although he began well by attending community based offending behaviour sessions in

which he was able to explore his own criminality, his conduct was at times unacceptable. In October 2005, he assaulted another hostel resident. In November, he accessed the hostel office telephone directory and listed on his own mobile phone the telephone numbers of the hostel staff. After this incident, the man sent a letter of apology to the Hostel Manager, and then faxed the Deputy Chief Officer of the probation area a request to be recalled to prison. The Deputy Chief Officer told him that there was no such provision. Later that month, the man was warned about his attitude towards the Hostel Deputy Manager. In December, he was given a verbal warning about the amount of alcohol he was taking and about his habit of returning late to the hostel.

In January 2006, the man maliciously damaged the property of another hostel resident whom he had apparently been bullying. In February, he received a written warning from an Assistant Chief Officer for returning to the hostel under the influence of alcohol and behaving aggressively towards a fellow resident.

On 21 March 2006, a Probation Service Senior Manager submitted a formal recommendation that in view of the man's unacceptable behaviour in the hostel he should be recalled to prison. The recommendation was accepted and he was returned to Preston the following day.

Preston: 22 March - 19 May 2006

The man arrived at Preston shortly after 11am on 22 March. The PER noted that he was a vulnerable prisoner, but there were no notations of any risk of self-harm.

That day, he seen by a nurse who wrote in his medical record that his weight was 74.4kg, his blood pressure was 140/70 and his pulse was 70. The nurse also referred him to a doctor with regard to his medication.

Also that day, a cell-sharing risk assessment was completed for the man. The form noted that he had no concerns about sharing a cell, but that he had previously been subject to self-harm monitoring procedures. The man was assessed by an officer as presenting a low risk of harm to others. However, the nurse who completed the healthcare section of the form assessed him as presenting a medium risk. The nurse wrote in section 3 of the form that the man said he had "no intention to self-harm at present".

On 23 March, the man underwent a custody care plan assessment. In the record of the assessment it was noted that he felt that there were no family issues for which he needed any support, but that he was concerned about his council tax debts. He was keen to be assisted in his quest for employment after release and told staff that he wanted someone to give him advice about the education courses available. He declared his ambition to get a degree at university so that he could "work with the environment". He also admitted that he suffered from depression and that he was receiving treatment for it. He told his interviewer that he did not know why his licence was revoked,

although he did admit to having had an argument with the hostel manager. He said that he nevertheless expected to be back in custody and that he had no thoughts of self-harm.

That same day, the man underwent an initial health screen. This was completed by the nurse who had seen him briefly on the previous day. The nurse noted that the man had, during the previous few months, seen a doctor for depression and high blood pressure, and that he was currently taking medication for physical ailments. The man also told the nurse that in the recent past he had fallen into a hole and had sprained his right ankle. He reaffirmed his allergies to penicillin and fish. As far as his mental health was concerned, the man told the nurse that he had never received treatment from a psychiatrist, but was currently taking medication for mental health problems. He admitted that in June 2005 he had drunk half a bottle of vodka and inhaled exhaust fumes. No other details of this event are recorded or explained in the record. The man told the nurse that he did not currently feel suicidal and had no intention of harming himself "at the present time". The nurse decided to refer the man to a doctor with regard to the medication he required. He was assessed as being fit for normal location

It is not clear either from the man's medical record or the prescription charts made available to my investigator whether he did in fact see the doctor.

Between 23 March and 19 May, very little information was recorded in the man's wing history sheet about what events occurred or about his demeanour.

On 27 March, the man moved from the induction unit to A Wing. Initially he was allocated to cell A5-24 but, later that day, he was moved to another single cell that he used as no more than a night time base. During the day, he worked as a healthcare centre cleaner.

On 2 April, the man was granted enhanced status and the associated privileges.

On 13 April, the following entry was made in the man's medical record:

> "Requests for a letter to solicitors to suggest that his brief anger with hostel manager whilst on licence was probably caused as a side effect of …….. Also request for report……. Plan: Advised to see psychiatrist for such assessment and possible reports…"

(Once again, the gaps represent words that are illegible and the signature of the author of this entry is also illegible.)

It was suggested to my investigator that this was an attempt by the man to portray himself as suffering from an illness that he could use as an excuse for his poor behaviour in the hostel. In the event, he did not follow up the advice to see a psychiatrist.

On 15 May, the man's recall to prison was considered by the Parole Board. The panel's conclusions were as follows:

> "The panel does not consider that the man is currently suitable to be re-released on licence. It was not persuaded, given his poor behaviour including aggressive behaviour at Approved Premises and alcohol use during the licence period and despite repeated warnings, that he would be any more motivated to comply with a further licence period. The panel is not satisfied that the benefits of release under a further period of supervision outweigh the risks and concludes that until further work has been undertaken on risk factors identified by the supervising officer, he poses an unacceptable risk for re-release. The man is entitled to a further review in 12 months time."

It is not clear whether the man received the details of the Parole Board's decision. However, on the same day, he sent the following written request to the Probation Department at Preston:

> "Could Probation Department please confirm that my Probation Officer/Case file has been transferred to where I intend to live upon eventual release, as I won't be living further from my elderly and infirm father any longer. Living so far from there so soon after my mother's death, coupled with the attitude/actions of the hostel manager caused problems and anxieties and stress which led to me shouting at the manager and my recall. Could you confirm that it is likely I will serve to the end of my sentence in 2008? I can start planning for my release by seeking accommodation. Thanks."

On 16 May, a nurse was told by a secretary who worked in the healthcare centre that the man had used a photocopying machine. Two members of staff confronted him with this accusation and he admitted that he had used the machine to photocopy the details of television programmes from a magazine. He was dismissed from his job and returned to his wing.

On 18 May, a Probation Officer responded to the man's letter of 15 May. She provided him with information about how he should apply to have his case transferred. She also sought to answer his question about the timing of his release. She wrote:

> "In relation to your query about how long you will be serving. Your case was reviewed by the Parole Board initially on return to custody. The recall was upheld and it was deemed appropriate that you would remain in custody until your sentence expiry date of 22/10/08. However, as you are serving a lengthy sentence your situation will be reviewed automatically in 12 months' time, again by the Parole Board. If they feel that you have made efforts to address your

offending behaviour and other issues, they may decide to release you earlier."

At interview, the Probation Officer told my investigator that she would probably have received the man's letter on 16 May. She thought it likely that, soon after the Parole Board had met and upheld the man's recall to prison, the clerk to the Board would have communicated their decision to the prison. However, the Probation Officer was uncertain as to who told her about the Parole Board's decision. My investigator later spoke to the Parole Clerk at Preston. She confirmed that it was the usual practice of the Parole Board to fax the details of their decisions to prisons on the day of the hearing. The Parole Clerk also said that she would normally send a memo to the prisoner concerned as soon as possible afterwards. She added that she would normally attach to the memo a copy of the fax from the Parole Board. The Parole Clerk said that, if the prisoner concerned was subject to self-harm or suicide monitoring procedures, a member of staff would be told of the contents of the memo and asked to see the prisoner in person, especially if the memo contained bad news. Finally, the Parole Clerk confirmed that any written communication about parole is normally placed in the prisoner's core record. She was unable to recall what had happened in this man's case. My investigator could find no documents in his core prison record relating to the timing of any communication from the Parole Clerk about his recall.

The Probation Officer said that, on 18 May, she would have typed her letter to the man, placed it in an envelope addressed to him, and put the envelope in an internal post tray in the Probation department. The envelope would then have been collected by one of the administrative staff in that department and taken to where the prison-wide pigeon holes are located. The Probation Officer told my investigator that, when the man was found hanging on 19 May, his letter was still in the possession of wing staff. My investigator talked to some of the staff who were on duty in A Wing that day, but none of them could recall handling the letter. Because it was still in the possession of staff, the Probation Officer was sure that the man had not seen it and that this could not have been the trigger for his apparent suicide.

The Probation Officer could not be sure as to whether the man had found out from another source that the Parole Board had upheld his recall and that he was therefore likely to remain in prison for some considerable time.

Key events on and after 19 May 2006

19 May

At 7am on 19 May, an officer carried out the first day-time roll check on A wing. The officer told my investigator that the first thing she did when she came on duty that day was to ask the staff on the night shift whether there were any matters to be handed over to her. She could not recall anything being said about the man. Although the officer confirmed that she checked every cell in the wing that morning, she could not specifically recall the details

of her check of the man's cell. She could not therefore say anything about his demeanour at that time.

At 8:15am, the man, who was in a single cell, took his breakfast. Thereafter, as he was unemployed, he remained in his cell until 11.45am. At that time, he left his cell to collect his lunch meal from the wing servery. Having done so, he then returned to his cell to eat his meal.

At 1:30pm, all the cells on the man's landing were unlocked so that dirty meal trays could be collected by the wing cleaner.

Shortly afterwards, a Probation Service Officer saw the man in his cell to book a sentence planning interview with him for 8:30am on the following Monday morning (22 May). She told my investigator that she spoke to him for two or three minutes. She said that, had she had any reason to think that he was suicidal, she would have opened an ACCT form. To her, the man appeared to be alright.

Between 2pm and 4pm, the man took part in wing based association. When the association period came to an end at 4pm, he returned to his cell.

At about 4:45pm, an officer unlocked the man from his cell to enable him to collect his tea meal. The officer did not see the man as he did so. As he was the only officer on the landing, he had quickly to unlock all the cell doors and could not therefore stop at each cell to observe the occupant(s). However, at interview, the officer said that he stationed himself at the wing servery and remembered noticing that the man had very little food on his plate. He said to the man, "Is that all you are eating?" He replied, "That's all I want, boss." The prison chaplain also remembered talking to the man at this time, as did a Senior Officer. Neither the chaplain, nor the Senior Officer nor the officer saw anything in the man's demeanour to suggest that he was contemplating suicide.

The man then returned to his cell to eat his meal. At about 5:15pm, the officer locked all prisoners on the landing into their cells and then went off duty.

At 6:15pm, another officer began to unlock the cells on A3 landing so that the wing orderly could collect the dirty meal trays from each cell. As the officer unlocked the man's cell, he shouted "trays" and turned to go back to the cell next door to lock the cell door. As no tray was immediately passed out of the man's cell, the orderly entered the cell and shouted the name of the officer. The latter returned to the man's cell and saw that he was suspended from the upper bunk by a ligature made from a bed sheet. The man was in a sitting position with his full weight held by the ligature. As the officer entered the cell, the orderly was already in the process of trying to support the man's body weight. The officer shouted to the wing manager to summon assistance.

The wing manager, who was at that time unclear why the officer had shouted to him, used his radio to ask for assistance at the cell. He then joined the

officer and the orderly who, by this time, were both supporting the man's body weight and attempting to remove the ligature. The wing manager removed the ligature knife on the officer's belt so that he could use it to cut the ligature away. However, he found that the angle at which he had to work was such that the ligature was too thick to cut. He therefore tried to undo the knot at each end of the ligature but was unsuccessful. The wing manager then moved around the officer and the orderly to gain a better position from which to cut the ligature. This time he was successful. At interview, the wing manager told my investigator that the time lapse between entering the cell and finally cutting the ligature was about 30 seconds.

Once the ligature had been removed, the wing manager, the officer and the orderly together lowered the man to the cell floor and laid him on his back. The wing manager checked to see whether there were any vital signs. He found that the man had no pulse and was not breathing. He described the man as cold to the touch and blue in colour. He commenced cardio-pulmonary resuscitation (CPR). After the second set of chest compressions, vomit appeared at the man's mouth. He was therefore placed on his side so that steps could be taken to remove the vomit from his mouth.

The wing manager repeatedly removed body fluids from the man's mouth with his fingers as, later on, did another officer. At this juncture, a colleague arrived at the cell with a pocket mask which he placed over the man's mouth and nose to provide protection. In spite of the wing manager's best efforts to clear the man's airway, it remained blocked by body fluids. Nevertheless, those staff in the cell continued to apply a combination of chest compressions and rescue breaths. At this point, the orderly was guided away from the cell to a Care Suite in the wing where an officer sat with him for some time.

An ambulance was called at 6:25pm.

At about 6:27pm, after further CPR had been applied by the wing manager, a healthcare officer arrived at the cell, followed quickly by another officer. The healthcare officer was in the healthcare centre when he heard an urgent message sent out over the radio requesting staff assistance on A3 landing. As the nature of the emergency was initially not transmitted, he took no emergency first aid equipment with him. However, a colleague heard a second radio message very shortly after the first in which a "Code 1" message indicated a life-threatening emergency. He therefore proceeded to A Wing, taking with him an emergency first aid bag.

Staff continued the efforts to revive the man using CPR techniques. The wing manager left at this point in order to create more work space in the cell.

On arrival at the cell, the healthcare officer asked the other members of staff to make room for him so that he could make his own assessment of the man. He checked to see whether he was breathing and checked his carotid pulse. The healthcare officer could find no signs of life. He gave the man two initial "rescue breaths" to see if his chest would rise. It did not. With the assistance

of colleagues, the healthcare officer continued to try to clear the man's airway so that CPR techniques could be applied.

Another healthcare officer then arrived with an automatic external defibrillator which was attached to the man. The defibrillator advised not to shock. CPR techniques were applied until about 6:35pm when a paramedic crew arrived.

The paramedics decided to move the man to the landing where there was more space. At their request, an officer cut the man's clothes away from his body. The paramedics then applied their defibrillator and this time an electrical current was administered to him. A healthcare officer assisted by applying a hand held ventilator. The paramedics again attempted to clear the man's airway and inserted a cannula. They then injected him with adrenalin and atropine. Sadly none of these measures succeeded in reviving him. The leading paramedic therefore pronounced him dead at 6:46pm.

The man's body was then wrapped in an orange blanket and was placed back in his cell. Staff briefly searched the cell to ascertain whether he had left a suicide note. None was found.

The Governor of Preston, together with other senior managers and the Independent Monitoring Board (IMB), were informed of the emergency by the Duty Governor of the day. The Governor and the IMB chairman attended the prison during the evening, and at about 7pm were present at a debrief of staff chaired by the Duty Governor.

The Duty Care Team member had left the establishment shortly before the man was found hanging. Almost immediately after her arrival at home, some 40 minutes' drive away, she was called by the prison and told what had happened to him. Without any hesitation, the Duty Care Team member returned to the prison to offer support to those staff involved in responding to the emergency. At interview, she pointed out that no room was set aside for Care Team members to see staff in conditions of privacy, but the Governor was aware of this and had agreed to examine what facilities could be made available.

Arrangements were made to review all those prisoners subject to self-harm monitoring procedures.

The police attended the prison at 7:45pm and took photographs of the man and his cell. His body was removed from the prison by the undertakers at 9:30pm.

That evening, the Duty Governor took responsibility for informing the man's next of kin of his death. In the prison file initiated in respect of the man's recall to prison on 22 March 2006, no next of kin details were recorded as it would appear he had offered no such information. The Duty Governor, with the assistance of the chaplain, contacted the Approved Premises in which the man had been a resident whilst on licence. The hostel staff were able to confirm that the man's next of kin was his father. The Duty Governor and the

chaplain made the decision to travel that night to the address they had been given so that they could break the news of the man's death to his father in person rather than on the telephone. However, upon their arrival at the address, they were unable to gain a response either by knocking on the door or by ringing the telephone number of the house. They therefore rang the Governor who advised that they should return to their homes and that he would arrange for the next of kin to be told the following day.

At consultation stage, the man's sister pointed out that, in fact, her father was in his house at time the prison staff arrived. He had gone to bed and had taken his hearing aid off. He was therefore unable to hear the telephone ringing or anyone knocking on the front door.

20 May

At about 9.30am the next day, in view of the difficulties experienced the previous evening, the Duty Governor of the day decided to contact another person who had been listed as the man's next of kin in his hostel records. The Duty Governor informed that person of the man's death. The person said that he wanted to be contacted again after the family had been informed. He provided the Duty Governor with the address of the man's sister. He also said that the man's father was probably staying with her. Immediately after this call, the Duty Governor rang the Lancashire Police to ask them to arrange for the man's sister to be informed of her brother's death. At 1:45pm, the Lancashire Police contacted the Duty Governor to confirm that the Yorkshire Police had visited the house where the man's sister lived and had found that nobody was in. By 4:45pm, the police had still not been able to find her. The Duty Governor therefore sought advice from the Governor who advised him to ring the man's sister on a number provided by the chaplain. This number had been acquired from the file opened in respect of the death of the man's mother the previous year.

When the Duty Governor called the number, he was connected to a voicemail system. He therefore left a message for the man's sister to contact him at the prison. She did so at about 5pm**.** At consultation stage, the man's sister clarified that the police had told her of her brother's death some time after 5pm on 20 May.

ISSUES

Were the man's mental health needs appropriately assessed and managed?

The man underwent an initial reception health screen and a well man assessment upon his arrival at Preston on 29 July 2005. He admitted that he suffered episodes of depression and was prescribed Dothiepin. He also told staff that, prior to his imprisonment, he had taken an overdose of paracetamol. An ACCT form was opened immediately but, after review, was closed the next day.

On 4 August, the man saw a GP in the prison very soon after learning that his mother had died. He told staff that he did not want to attend his mother's funeral as he did not want his father to know that he was in prison. The GP changed his medication from Dothiepin, which apparently caused stomach pains, to Venlafaxine and Zoplicone so that he could sleep properly at night.

Very soon after his arrival at Wymott prison on 8 August, the man began to show signs that he was not coping with his mother's death. As a result, a F2052SH was opened. His medical record contains entries that suggest he was "stressed out" but not suicidal, and that he was taking antidepressant medication. The F2052SH was closed on 11 August. I am concerned that, as I have indicated earlier in the report, the document has subsequently been lost.

The man was released on parole from Wymott on 8 September to an Approved Premises. There is no evidence in his medical record to show that he had been assessed as fit for release from prison or that his mental health needs had been communicated to any outside agencies so that appropriate support could be given. However, upon his arrival at the hostel, the man was seen by a Probation Officer who expressed no concerns about his mental well being, although she did suggest to him that he should participate in bereavement counselling. The man kept an initial appointment, but decided that he did not need further support. The Probation Officer also referred the man for support to reduce his alcohol consumption. The man attended some of these sessions.

Whilst he was at the hostel, the man also undertook a "Life Map" which referred to many unhappy memories, particularly that of the death of his mother which he described as "the single most devastating event" of his life.

On 22 March 2006, the man was recalled to prison because of his unacceptable behaviour at the hostel. On 20 April, he declared that, mentally, he was feeling better and wanted to reduce his antidepressant medication. He did not come to the attention of any of the healthcare staff again.

The author of the clinical review of the management of the man's healthcare needs concludes that there is no evidence to suggest that his mental

healthcare required additional input. I am inclined to agree. However, I am concerned that no effort appears to have been made by healthcare staff at Wymott to pass on to any outside agencies the details of the man's mental health needs so that appropriate support could be given to him after his release on licence on 6 September 2005. Fortunately, after completing their own assessment of the man upon his arrival at the hostel, the Probation Service took steps to offer him bereavement counselling and other forms of help.

The Governor of Wymott should remind healthcare staff of the importance of passing on to appropriate agencies details of prisoners' healthcare needs at the point of release on licence or final discharge.

Clinical Review

Whilst the clinical review concludes that there was no further evidence to suggest that additional mental health input was required, the following areas of concern were identified (I quote directly from the clinical review):

- Prison Officers, it would appear, are not generally trained to provide basic resuscitation. The Heartstart programme is not delivered to staff on the "shop floor". The officer who did undertake CPR had not received an annual update for over two years and it was by his own admission his first attempt on a person, as opposed to a resuscitation training "dummy".
- The nurse who took over from the prison officer has until recently been undertaking mental health training for three years and could not clarify the date when he last undertook a CPR update but felt that it was in the last year or so during his training.
- Nursing staff employed a defibrillator but stated that they were not trained to use it. They used it to monitor cardiac activity. What would staff have done if the defibrillator had stated that defibrillation was indicated?
- There appears to be a lack of continuity for mental health care particularly for those who would benefit from primary mental health input. The focus is on enduring/severe mental illness which means that many people are not getting the opportunity to access alternative support for depression eg counselling as opposed to medication.
- Mental health work appears to be done in isolation and records of any input not recorded centrally for all healthcare personnel to access which could influence clinical decision making.

The Prison Health partnership should consider the findings of the clinical review and develop an action plan to address the identified learning points.

Was the man's risk of self-harm or suicide properly assessed, monitored and managed?

The man entered prison on 29 July 2005 with a history of depression. He was anxious that his parents should know neither the fact of his imprisonment nor the reasons for it. His mother, to whom he was very close, had been diagnosed with terminal cancer. She did not have long to live. These are factors that were likely to make him a high risk of self-harm.

It is particularly pleasing to note that on the very first day of his imprisonment, an urgent fax was sent to reception staff at Preston by the duty Probation Officer in the prison. The Probation Officer wanted the reception staff to be aware of the concerns that had been expressed in a pre-sentence report to court. As a direct result of that communication, the nurse on duty in reception decided to instigate self-harm monitoring procedures straightaway, despite the fact that she did not consider the man to be suicidal at the time.

(I commend the Probation Officer for faxing such important information so promptly to the reception staff. I also commend the nurse for reacting immediately by opening an ACCT form. Two further notes of commendation are included in my recommendations.)

The investigation found that the self-harm monitoring procedures invoked for the man upon his reception at Preston were appropriate. A comprehensive ACCT assessment interview was promptly conducted by a trained member of staff. The assessment correctly identified a number of self-harm risk indicators, including the threat of the death of the man's mother, the impact of imprisonment upon the man, the possible reaction of other prisoners to the nature of his offences, and the fact that he had taken an overdose of tablets before being imprisoned. The conclusions drawn by the assessor about the risk of self-harm that the man actually presented were realistic. He considered that the man did not show any signs of being actively suicidal at interview. The man told the assessor that, whilst he dreaded the thought that his mother might die, her death would not lead to a self-harm attempt. In my view, the assessor's belief that there was very little risk of his self-harming in the remaining six weeks of his period of custody was justified. The ACCT assessment was immediately followed by a case review at which the man was present. That review concluded that the ACCT form could safely be closed. In the circumstances, I believe that this judgement was appropriate.

However, in the record of both the ACCT assessment interview and the ACCT case review that followed, references are made to the fact that the man had been a Listener during a previous sentence. The author of the record of the assessment interview wrote that the man was therefore "fully aware of all the support available to him in prison and how to access it." This statement carries with it the inference that, because he had previously been a Listener, no explanations of the support mechanisms available at Preston were offered to the man. The record of the interview held on 30 July is not clear on this point. Whilst I do not make any formal recommendations about this, I nevertheless believe that staff should guard against the danger of

assuming that it is not necessary to explain to former Listeners the means by which they can receive support tailored to their individual needs.

A post-closure review was scheduled for 9 August. This was overtaken by the man's transfer to Wymott prison the day before the review was due. Upon his arrival at Wymott, a form F2052SH was opened for a short while. Notwithstanding these developments, arrangements should have been in place to guarantee a post closure review of the man.

The Governor of Preston should review the current local policy for the convening of ACCT post closure reviews to ensure that such reviews can take place irrespective of the transfer of prisoners for whom an ACCT has been closed.

Loss of F2052SH

The documents presented to my investigator at Preston did not include the F2052SH used at Wymott. My investigator was advised by the Suicide Prevention Co-ordinator at Wymott that the log of F2052SH documents still available at Wymott confirmed that a F2052SH had indeed been opened for the man on 9 August. The Suicide Prevention Co-ordinator also confirmed that the closed document should have been forwarded to Preston as soon as the man returned there in March 2006. She could not account for the absence of the document from the man's core record. The Suicide Prevention Co-ordinator asked her staff to search the archive room at Wymott. However, the document was not found.

The loss of such an important document as a F2052SH or ACCT form is unacceptable, no matter what the paperwork and storage pressures are on establishments.

The Governor of Wymott should ensure that proper arrangements are in place for the safe storage of closed F2052SH and ACCT documents in prisoners' core records.

What might have triggered the man's apparent suicide? Could his death have been predicted?

A number of factors may have contributed to the man's demise, including:

- his mother's death
- his recall to prison
- being dismissed from his job as an orderly in the healthcare centre.

Here I examine each factor in turn.

His mother's death

When the man was told of his mother's death on 4 August 2005, he said that he did not wish to go to her funeral lest his father found out that he was in

prison. Initially, he took the news relatively well. However, the same day he told a prison doctor that the news had not yet hit him and that he would need something more to help him. The doctor changed his medication to help him sleep better. Four days later, the man was transferred to Wymott. On his arrival there, he was described by a doctor who saw him as being "stressed out" because of his mother's death and "not coping". A F2052SH was opened on 9 August.

It is clear from these events that the man was affected by the death of his mother, the news of which took a few days to sink in. However, as time went on, he appeared to improve. The F2052SH was closed on 11 August. In the 'Life Map' he completed at the hostel, he referred to his mother's death as the single most devastating event of his life but, thereafter, there were no other notations in his medical record or in his core prison record in relation to her passing. At no stage did the man give any obvious signs that his mother's death was making him feel suicidal.

His recall to prison

The fact that the man was recalled to prison after a relatively short period on parole must have contributed significantly to the deterioration in his morale. The Probation Officer explained to my investigator in great detail the method by which she arranged for the man to receive a reply to his request in May for information about changing his Probation Supervisor and how long he would have to serve. She was certain that the man did not receive her reply before he died, as the envelope containing it had not reached his cell. My investigator talked to some of the staff who were on duty in A Wing on 18 and 19 May, but none of them could recall handling the man's letter. I judge, therefore, that the suggestion in the Probation Officer's letter that the man might have to remain in prison until 22 October 2008 when his sentence was due to expire is unlikely to have been a contributory factor in his death. It is, of course, possible that he had received this information from another source, but the investigation uncovered no evidence to confirm this.

Being dismissed from his job as a healthcare centre cleaner

The man's outward behaviour gave no obvious indication that he had reacted badly to his dismissal from his employment as a healthcare centre orderly. Furthermore, there is no evidence that he complained about it to staff. A prisoner who regularly saw the man during meal times spoke to him on the day he was dismissed. The prisoner thought at the time that he 'shrugged off' the bad news. The prisoner also told my investigator that the man never gave any visible signs that he was unhappy, preoccupied or subdued. Whilst I think that the loss of his job is likely to have contributed to a deterioration in his morale shortly before his death, I cannot say it was a trigger point. Neither do I criticise the staff who decided to dismiss the man. In my view, it was a legitimate and justifiable response to his improper use of the photocopying machine.

With the benefit of hindsight, it may be felt that the combination of losing his mother and being recalled to prison combined to weigh so heavily on the man as to cause him to consider suicide. His dismissal from his job as a healthcare centre orderly could have been the last straw. There may also have been other, unknown, factors at work. Certainly, I am conscious from this and other investigations that those recalled to prison are at special risk of self-inflicted death. However, at the time, the man gave no indication that he was feeling suicidal and staff had no reason to invoke special measures such as placing him in a shared cell or instigating formal self-harm monitoring and support.

Record keeping

The investigation found that between 23 March and 19 May 2006, scant information was entered in the wing history sheet of the man's core prison record about his demeanour.

The Governor of Preston should remind staff of the importance of making descriptive entries in prisoners' records about their behaviour, attitudes and progress through their sentence.

The investigation also found that some entries made in the man's medical record at Preston and at Wymott were illegible. So too were some of the signatures written in the margins.

The Governors of Preston and Wymott should, in conjunction with their respective Healthcare Managers, take steps to ensure that entries and signatures recorded in prisoners' medical records are legible.

Next of kin details

The man's core prison record did not make clear who was his next of kin. Although every effort was made to break the news of his death to his family promptly, those efforts were hampered in part by confusion as to who his next of kin was and how contact could be made.

The Governor should ensure that appropriate steps are taken to update next of kin details recorded in prisoners' core records in order to minimise the risk of communications difficulties in the event of an emergency.

LIST OF RECOMMENDATIONS

At consultation stage, the Prison Service accepted all recommendations. The Service's responses are shown below.

To the Governor of Preston

1. The Governor should review the current local policy for the convening of ACCT post closure reviews to ensure that such reviews take place irrespective of the transfer of prisoners for whom an ACCT has been closed.

Prison Service response:

Post closure reviews will take place in liaison with the receiving establishment where possible and locally in all cases.

2. The Governor should ensure that appropriate steps are taken to update next of kin details recorded in prisoners' core records in order to minimise the risk of communications difficulties in the event of an emergency.

Prison Service response:

A Notice to staff reminding Reception staff of the need to record this information accurately and in all cases is to be issued.

It is now practice at Preston that whenever an ACCT document is opened the prisoner in question is asked for permission to record details of the next of kin in the ACCT document itself.

3. The Governor of Preston should remind staff of the importance of making descriptive entries in prisoners' records about their behaviour, attitudes and progress through their sentence.

Prison Service response:

Making informative entries in history sheets now included in officer job descriptions/ Staff Planning and Development Reports. Principal Officer Action Plan in place to improve overall quality/frequency of personal officer entries.

4. The Governor should, in conjunction with the Healthcare Manager, take steps to ensure that entries and signatures recorded in prisoners' medical records are legible.

Prison Service response:

A notice to all medical staff with access to prisoners' medical records, reminding them of the need to make legible entries at all times, will be issued by the Primary Care Manager.

5. The Prison Health partnership should consider the findings of the clinical review and develop an action plan to address the identified learning points.

Prison Service response:

Local PCT Management will consider the findings of the Clinical Review and formulate an action plan based on those findings.

Commendations

1. I commend the Probation Officer for faxing important information about the man's risk of self harm so promptly to the reception staff on the day of his arrival at Preston. I also commend the nurse for reacting immediately by opening an ACCT form.

2. The efforts of staff to revive the man were especially praiseworthy. The assistance given to staff by the prisoner who was the first to discover the man hanging merits particular note.

3. I also draw particular attention to the duty Care team member who, on 19 May 2006, took it upon herself to return to Preston after a 40 minute drive home, in order to offer care and support to those staff who were involved in discovering and applying first aid to the man.

(I would be grateful if the Governor could share my commendations with all the staff concerned and with the prisoner.)

Prison Service response:

A letter of commendation from the Governor will be sent to the individuals concerned.

<u>To the Governor of Wymott</u>

1. The Governor should remind healthcare staff of the importance of passing on to appropriate agencies details of prisoners' healthcare needs at the point of release on licence or final discharge.

Prison Service response:

Release letter given to all prisoners. Health needs referred to relevant NHS agencies.

2. The Governor should, in conjunction with the Healthcare Manager, take steps to ensure that entries made in prisoners' medical records are legible and that so, too, are the signatures of the persons who make entries.

Prison Service response:

Notice to staff to be issued to print name and designation alongside all signatures. Weekly management check to be conducted on 10 records. Guidance to be included on healthcare induction programme.

3 The Governor should ensure that proper arrangements are in place for the safe storage of closed F2052SH and ACCT documents in prisoners' core records.

Prison Service response:

A new muniments room has been built which now allows for the storage of records to be all in one place. ACCT documents are quality checked by the ACCT coordinator and then passed to the custody admin department for filing in the core F2050. A proforma has been devised which acknowledges receipt of ACCT documents for storage. The system will be put in place as soon as possible.

Family concerns:

At consultation stage, the man's sister expressed her concerns about the manner in which the Prison Service conducts self-harm risk assessments and about the manner in which bad news is communicated to prisoners. Whilst I have made no formal recommendations on these matters, I have agreed to include the full text of her comments. She wrote,

- **Self harm risk assessments**

"I feel strongly that some consideration should be given to monitoring the 'organic' risk/vulnerability factors for men who are not obviously suffering /reacting. In an institution in which relationships can be significantly disrupted by prisoner re-location and staffing changes, it is clearly possible for a man to be 'among strangers' who are less likely to have a knowledge/understanding of what has gone before, and for whom a setback today may reverberate much more deeply than might present on the surface."

- **Communication of bad news to prisoners**

"I am aware that the issue of my brother having received the letter from Prison Probation staff, notifying him of the Parole Board decision, before his death, is unclear, but, seemingly, he was less likely to have not, rather than to have, seen it. I would feel strongly that the decision to issue a letter/reserve the right to first speak to the man in person about such an important matter could be guided by an 'organic' system of risk evaluation. Similarly, staff in

direct overview of the man delivering bad news, would benefit from a contextualised understanding – especially given the limited nature of the relationship the setting can allow for, as my brother's circumstances illustrate."