



**Investigation into the circumstances surrounding the
death of a man at HMP Swaleside
In March 2011**

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

April 2012

This is the report of an investigation into the death of a man. He was found hanging in his cell at HMP Swaleside in March 2011. He had recently been sentenced for making threats to kill and had been previously recalled to prison having broken the terms of his licence. He was 41 years of age.

I extend my condolences to the man's family. I hope that my report goes some way to answering any questions they may have.

The investigation into the man's death was undertaken by a senior investigator from this office. A clinical review was conducted by a clinical reviewer on behalf of the local Primary Care Trust (PCT). His review is the first annex of this investigation report. I am grateful to the Governor and staff of Swaleside for their co-operation with the investigation. I apologise for the delay in producing this report.

This is the fifth apparently self inflicted death at Swaleside since the Ombudsman started investigating such deaths in April 2004, the last of which was in April 2010. There are no similarities between the man's death and previous deaths at the prison.

The man showed no signs that he was suicidal in the days leading up to his death, although he left two letters in his cell which indicated he intended to take his own life. Nevertheless, the investigation concludes that there was no evidence to suggest that his death could reasonably have been prevented by staff at Swaleside. Five recommendations are made to support improvement in cases such as his. These relate to continuity of healthcare, procedures for prisoners who have a change of circumstance, first aid training for staff, and procedures for calling an ambulance in relation to a death in custody.

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

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Prison and Probation Ombudsman

April 2012

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SUMMARY

1. The man was sentenced to six and a half years' imprisonment on 2 September 2006, for an offence of armed robbery. He was released on licence from HMP Highdown on 1 December 2009, to live at a local approved premise. (A licence sets rules and guidance to which a prisoner must adhere whilst living in the community. The licence is supervised by the Probation Service.) During this time he made threats to kill the man who had been convicted of the manslaughter of his mother.
2. On 8 January 2010, the man's licence was revoked and he was recalled to custody on 11 January, for his continued failure to comply with his licence conditions. He was sent to HMP Elmley and, during his time there, received treatment for his mental health and substance misuse issues.
3. Whilst at Elmley, the man experienced two family bereavements and was denied parole which resulted in Assessment, Care in Custody and Teamwork, (ACCT) procedures being instigated on 24 July. (ACCT procedures aim to help and monitor prisoners at risk of harming themselves. They are a shared responsibility to ensure staff create a safe and caring environment, identify prisoners' individual needs, and provide care and support before, during and after a period of crisis.) He was reviewed regularly and the ACCT was closed less than a month later, on 18 August.
4. On 28 September, the man was transferred to HMP Swaleside and the treatment for his substance misuse continued. He successfully completed his detoxification programme in December. At various times, in both Elmley and Swaleside, he was encouraged to engage with non-medical drug treatment programmes, but he did not wish to do so.
5. The man's records show that he had no contact with the mental health team until arriving at Elmley in January 2010, when his mental health was assessed as having improved significantly. He continued to experience ongoing anxiety about the death of his mother and his impending court case, and was advised that counselling could help.
6. On 3 March, the man was sentenced to two years and six months for the threats to kill offence. Although he told staff and other prisoners he was angry with the sentence, he did not show any signs of being suicidal.
7. The man was last seen alive on the evening before his death and was found in his cell the following morning. Staff responded immediately to the emergency code but there was no attempt to resuscitate him as rigor mortis had set in.
8. We make five recommendations relating to continuity of healthcare, first aid training for staff and procedures for calling an ambulance in relation to a death in custody.

THE INVESTIGATION PROCESS

9. The investigation was carried out by an investigator who visited HMP Swaleside on 22 March 2011. He met the Governor of Swaleside, the Head of Residence, Family Liaison Officer and the manager of F wing. No representative from the Prison Officers' Association (POA) was available to meet with him. Our investigator also met with a member of the Independent Monitoring Board (IMB). (IMB members are independent and unpaid. They monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained. The POA is the trade union for prison officers.) He also met the prison's Police Liaison Officer.
10. Notices announcing the investigation and its terms of reference were issued to both staff and prisoners at Swaleside. The notices were displayed around the prison and invited staff and prisoners to contact the investigator should they wish to do so. The investigator interviewed a number of prison officers and six prisoners who knew the man. The investigator also spoke with the man's friend, who got to know him when she worked for the Samaritans while he was serving the first part of his sentence.
11. The investigator was shown the cell in which the man spent the last days of his life. The investigator reviewed his prison and health records, and other documentation relating to the time that he spent at Swaleside. He also had access to transcripts of telephone calls made by him. During the course of the investigation, the investigator provided verbal and written feedback to the Governor of Swaleside. This office apologises for the lateness in the publication of the report however, this was due to work load pressures.
12. A clinical review was commissioned from the local Primary Care Trust (PCT) and was undertaken by a clinical reviewer.
13. The investigator has also been in contact with the Coroner's office and a copy of this report will be sent to HM Coroner for Mid Kent and Medway to assist her with her enquiries.
14. One of the Ombudsman's family liaison officers contacted the man's sisters to discuss the purpose and scope of the investigation and give the family the opportunity to raise any concerns they had about his death. The family liaison officer and investigator visited one of the sisters at her home. During the meeting she asked if it was usual for someone to be prescribed anti-psychotic drugs whilst on a detoxification regime. Despite drawing this question to the attention of the clinical reviewer, he did not comment on this matter and we have received no further response.
15. She also wanted to know whether her brother was Hepatitis C positive, as written in his probation records. We can confirm that according to his healthcare records, he received treatment for Hepatitis C during his time in custody. She also raised the following queries:
 - The reason that he was unable to attend his sister's funeral;

- The time at which he was last seen alive;
- Whether the television in his cell was on at the time of his death and, if so, if the volume was turned to loud.

In response to the draft report the family had identified a number of further questions/issues in relation to information from the annexes of the report. They would continue to pursue these at the inquest process and via the assistance of their legal representative who they had yet to consult regarding the report.

HMP SWALESIDE

16. HMP Swaleside is a category B prison that is part of the Isle of Sheppey cluster which also includes Elmley and Standford Hill prisons. (Category B prisons are for those prisoners whom the highest security conditions are not necessary, but for whom escape needs to be made very difficult.) The cluster of prisons on the Isle of Sheppey is managed by a Chief Executive and there are numerous shared services between the three establishments.

17. The last full inspection of Elmley, by Her Majesty's Chief Inspector of Prisons, was in 2008. She found that Swaleside:

“... has to manage a challenging population of serious offenders and it is therefore commendable that we found it to be a very safe prison. It was similarly pleasing to find that staff-prisoner relationships remained extremely good.”

18. In its report for the year 2009 to 2010, the Independent Monitoring Board (IMB) raised concerns in relation to Swaleside, concluding that:

“Despite the dedication and professionalism of the staff, following a number of serious incidents, the prison feels less settled and consequently less safe than in the previous year. Prisoner indiscipline has increased.

Swaleside is described as a “Training” prison but unfortunately the training responsibility is not under the control of the Senior Management Team. One of the disadvantages of clustering has been the lack of accountability of the Reducing Re-offending Team to the Governor for delivery of its functions.”

19. The man's death was the fifth apparently self-inflicted death in Swaleside since the Ombudsman took on the responsibility for the investigation of deaths in custody in April 2004. The last self-inflicted death was in April 2010. All deaths in custody are subject to investigation by this office, and there were no similarities between the circumstances of his death and the previous self-inflicted deaths at Swaleside.

KEY EVENTS

20. The man was sentenced to six and a half years in prison on 10 November 2006, at Crown Court. On 1 December 2009, he was conditionally released from HMP Highdown on licence to a local approved premises. Just over a month later, on 11 January 2010, his licence was revoked and he was recalled to HMP Elmley. He had repeatedly breached his licence conditions whilst residing at the premises. During his stay at the approved premises, he had also made threats to kill the man who had been charged with the manslaughter of his mother.
21. The man was seen by various healthcare professionals whilst at Elmley and assessed for mental health issues and substance misuse. According to his medical records, he had been diagnosed with, "mixed type dissociated borderline and emotional unstable personality disorder" at HMP Highdown. On 22 January, he was assessed by a psychiatrist with special interest in substance misuse. The doctor noted that he, "presumably suffers from borderline personality disorder."
22. The man told healthcare staff that he had been taking drugs since being a teenager and spent long periods of time in prison for offences related to his drug use. He engaged with the Integrated Drug Treatment System (IDTS) team in Elmley and was prescribed medication related to his drug use. (The IDTS team is a multi disciplinary team based in the prison working with prisoners who have substance misuse issues. The team works to improve the quality of and access to drug treatments including detoxification.)
23. Over the next few months, the man had contact with the mental health team. On 24 July a Registered Mental Nurse (RMN) started Assessment, Care in Custody and Teamwork (ACCT) procedures on him. This was following the news that his sister and his godfather had died. In interview, the nurse told the investigator she did this as a response to his level of distress as he kept saying he wanted to be "knocked out". She said she did not remember him saying he was going to harm himself but she started ACCT procedures as "a preventative measure".
24. The man's request for release on temporary licence (ROTL) to attend his sister's funeral was rejected. (ROTL means being able to leave the prison for a short time. For example prisoners may be granted ROTL to attend a funeral or because a parent or partner is seriously ill.) He was told that the security implications for his release of ROTL were too great, due to his threats to kill the man who had been convicted for the manslaughter of his mother. He was disappointed about this decision, but denied suicidal thoughts. He told staff that he just wanted some quiet time on his own. His medical records during this time note that he appeared, "fairly settled in mood and behaviour".
25. The man's ACCT was reviewed regularly and he reassured staff that he had no suicidal thoughts. On 18 August, his ACCT was closed and staff recorded that he was in good humour and was feeling positive. He said that he had never considered self harming and asked for the ACCT procedures to be closed.
26. On 28 September, the man transferred from Elmley to Swaleside. It was recorded on the Person Escort Record (PER) form that he had been subject to an

ACCT which was closed, and that there were no healthcare issues. (The PER is a form that accompanies prisoners on all journeys from and between prisons. It serves as a communication tool about risks a prisoner poses on escort or transfer.)

27. That same day, a nurse completed an initial health screen, when she noted his medication and that he had previously been seen by the mental health in reach team (MHIRT) and a referral was made to the doctor for substance misuse treatment. (The aim of the health screen is to identify any needs or health concerns that the prisoner might have. It identifies a prisoner's past medical history, including mental health.) She also recorded that he had not tried to harm himself and was not feeling at risk of self harm or suicide.
28. On 29 September, the man had a further IDTS review and it was agreed that his detoxification medication would be reduced weekly. He said he was not interested in relapse prevention work. The psychiatrist told the investigator that he, "persistently tried to connect him to counselling, to key work, to rehab work, to psycho-social help or to self help, such as Narcotics Anonymous. But he [the man] refused any kind of help".
29. An officer noted in his prison record that the man blamed his probation officer for not letting him go to the funeral of his sister and godfather. He telephoned his probation officer on 1 November. Apparently, they were concerned with the threat he posed to the man who killed his mother. He noted that he said he would, "... see the final two years of his sentence out and then he will not have to have probation involved when he is released as he will not be on licence".
30. At a Parole Board Hearing on 26 November, the man was not recommended for release due to his risk factors, although the panel did give him, "... credit for engaging with the drug detoxification team". (A parole board is a panel of people who decide whether an offender should be released from prison on parole after serving at least a minimum portion of their sentence.)
31. On 7 December, the man was discovered bleeding profusely from his right ear, claiming to have fallen, but having little recollection of the circumstances of the fall. Paramedics were called and he was taken to hospital. He discharged himself before he was seen at the hospital, and he was returned to Swaleside. He refused to be admitted to the inpatient department of the prison for observation and returned to his wing against medical advice.
32. The following day the man was taken to Crown Court for preliminary court hearings, but he refused to appear, stating that he was unwell. He was returned to Swaleside. That same day, he finished his detoxification programme.
33. Two days later, the man requested sleeping tablets because of symptoms he experienced after completing detoxification. He was given painkillers. Later that day, a nurse saw him and noted that he said he was experiencing ongoing withdrawal symptoms. He told the nurse that he realised he had not dealt with the grief from the bereavements earlier that year. She said in interview that he seemed to focus on his medications and was not interested in any other support.

The investigator asked her if he was more settled during the detoxification programme and after his ACCT was closed. She replied:

“I wouldn’t say he improved, I wouldn’t say he deteriorated. I think he was very fixed on certain things and he was quite reluctant to take any other form of support or help other than medication”.

34. On 24 December, the man was found on the floor of his cell bleeding from his ear. Later that day, he denied he had hurt his own ear in an effort to secure opiate-based medication. His urine tested negative for drugs. A doctor spoke to him, who assured him he did not want an opiate based painkiller. The doctor planned to observe him and review his condition later. However, a short time later the doctor was advised that the bleeding from his ear had worsened, and he was taken to hospital. The hospital doctor concluded that it looked like something had been poked into his ear. The medical record entry notes that on the return journey to Swaleside, he asked to see a member of the MHIRT as he had previously been under their care whilst at Elmley. He was advised to apply for an appointment using the application process on the wing.
35. A nurse saw the man on 10 January 2011, for a mental health review in response to his self referral. He told her he was experiencing negative effects from his psychiatric medications since finishing detoxification. She noted that he had only collected his antipsychotic medication on two occasions since 28 December. She requested a medication review from the psychiatrist and a referral to counselling services. It had been nearly one year since the nurse had seen him and she could not believe the difference in that time, telling the investigator that, “he was so much better than when I first knew him in Elmley, mentally much more stable, there was none of the distress”. She said although he had not been seen by the mental health team since his transfer to Swaleside he, “was obviously doing well otherwise he would have come to our attention”.
36. On 17 January, the man was reduced to the basic regime of the Incentives and Earned Privilege Scheme (IEP scheme) due to the discovery of “hooch” in his cell. (Hooch is the colloquial term to describe an alcoholic drink made illicitly. IEP is a system in all prisons to encourage responsible behaviour by prisoners. It operates on three levels: basic, standard and enhanced. Prisoners must consistently perform well to move to the next level. Basic is the lowest level and means that the prisoner will have restricted time out of cell and limited activity in cell, for example his television would be removed.)
37. Later that day, the man was assessed by a psychiatrist, who noted that he was low in mood but denied feeling depressed. He also noted that the man refused any antipsychotic or antidepressant medication. The psychiatrist said that, “he has had past psychiatric contact and I was not sure if this was related to past substance misuse rather than an enduring mental illness”. He felt the man was depressed in relation to his current court case and this had made him more reflective about his mother’s death. The doctor reflected, “... he has probably been used to illegal drugs and prescription replacements to help address these but now does not have these as a support structure”. He thought that the man’s mood would improve after the court case. Nevertheless, he was to be kept under

close review and advised to consider counselling.

38. On 21 January, a nurse noted in the man's medical records that he had seen healthcare because he had been having headaches for the previous two weeks, which had worsened in the last four days. He was advised to take painkillers. On the 26 January, another nurse agreed with healthcare that his prescription should be stopped as he continued not to collect it. She told the investigator that he could start his medication again if he wanted.
39. An officer noted in the man's prison record on 30 January that he had good reports from the wing staff, which was confirmed by a further entry by another officer on 1 February. However, at an IEP review a week later on 7 February noted that he was to remain on basic for a further seven days when his IEP status was to be reviewed.
40. On 7 February, a nurse reviewed the man's mental health and found him "settled and stable in mood". However, he told her he was, "struggling big time" and he felt "that without self medicating (opiates) his thoughts and feelings are too strong for him to manage", although he denied any current thoughts of self harm or suicide. He said that he recently wrote a letter outlining his early childhood and the abuse he, his sisters and mother suffered. He told the nurse that writing it all down had given him some insight into why he responds to certain situations with aggression. She noted that he was on a waiting list for counselling and she requested a medication review by the psychiatrist. In interview, she said he seemed exactly the same to her as he had been when she last reviewed him in January.
41. That evening, the man was seen by a nurse and taken to hospital because his ear had started bleeding again. He was seen by the doctor who said there must have been a trauma to the ear but there was nothing they could do, so he was returned to Swaleside.
42. On 14 February, at an IEP review a Senior Officer (SO) noted that the man had been returned to the standard regime. He said that reports from wing staff were generally good and noted that he understood if he received any negative reports in the next 28 day period he would be returned to basic regime. In interview with our investigator, the SO said although he had very little personal contact with him, he appeared settled in prison and, "didn't appear to be involved in anything subversive or disruptive".
43. The man attended Crown Court on 3 March and received a further sentence of two years and six months for the offence of threats to kill. There is a prison record entry which states the offence type and date of sentence. There was no recorded health screen in reception when he got back to the prison that day.
44. An officer saw the man when he returned from court that day and spent some time talking with him on the wing. She said that he was angry with his sentence although did not express any thoughts of self harm or suicide. She said that, "... he seemed rather more together than what I actually thought he was" and told our investigator that when a prisoner has "... had a bit of bad news and its STBA-

Staff To Be Aware-it's always noted in books and things like that: staff to be more aware of this person". She could not remember if this was noted in his records but she did say the officers talked about it between themselves and agreed, "... to keep a bit of an eye on him". She said he had calmed down when she saw him in the evening at association time (this is social time when prisoners are allowed out of their cells but remain on the wing) as he was laughing and playing pool.

45. The man telephoned his friend later that evening. She told the investigator that he was unhappy about the sentence, but she was not unduly concerned about him.
46. The same day as his court appearance, an officer noted that the man had settled back down on the wing after his recent spell on the basic regime. He told the officer that he was keen to put it behind him and once again wished to progress to an enhanced IEP level. The officer noted that he had recently been assisting staff on the wing by helping out behind the hotplate area, working to a good standard.
47. A nurse saw him for his next review on 10 March, and she noted that he presented as low in mood due to his recent sentencing. He told her that he would not engage, "... with anyone or anything, particularly probation who he stated had 'stitched him up'". He said he was just going to sit in his cell and complete his sentence. He denied any thoughts of self harm or suicide and said he did not want to be prescribed any medication. She told the investigator that he did not seem any different to how he had been in the review meeting in February and "still presented as ok". She said he was angry that the man who killed his mother had received a lesser sentence than him. She asked him if he would like to see the psychiatrist to discuss medication but he refused. She planned to review him in four weeks. She told the investigator that at no point in this meeting or in all her contact with him did she think he was at risk of self harm or suicide.
48. According to his records, he continued to perform his cleaning duties to a good standard on the wing and maintained a good relationship with the wing staff. However, one entry on 17 March suggested that he was very unhappy about a recent meeting with probation. It was also observed that he was upset at having additional years added to his sentence due to a comment he made to probation staff.
49. The investigator interviewed Prisoner A, who described the man as, "his best friend on the wing". He said that on the Thursday or Friday before the 19 March, he had told him that he was, "going home by getting himself into hospital and then doing a runner from there". The prisoner said he "knew he was not being serious", having said this before, so he did not take any notice. Prisoner B told the investigator that he had played chess with him on the evening of Friday 18 March.

Saturday 19 March 2011

50. On the morning of 19 March, Prisoner C spoke with the man. He told the investigator that he “appeared no different to usual” and “was not upset or down”. Another prisoner said in interview that the man had visited him in his cell on the afternoon of the 19 March and told him he would give him his television set but gave no explanation. He said that he showed no signs of feeling down or depressed. He asked him if he would play a game of chess with him but he said he did not want to. He told our investigator that the man had given him some coffee and sugar that morning but he, “did not think anything was out of order”.
51. The man was last seen alive in his cell by an Operational Support Grade (OSG) at 8.05pm on the evening of 19 March. At this time, the man had asked him to turn off his cell light (operated by a switch outside the cell) which the OSG did. He told our investigator that this was not an unusual request. He said that at no point during the evening did he ring his cell bell nor did he have any reason to check on him.
52. The prisoner who occupied the cell next to the man said in interview that he did not hear anything during that night. He said that he had noticed him being quieter and a little withdrawn in the last week but he, “showed no signs or indications that he would do what he did”.
53. Prisoner C told our investigator that, “unusually at about 11.30pm to 12.00am the man’s television was turned up “loud”. Prisoner A also said he had heard his television turned up unusually high at around 11.00pm to 11.30pm that evening. The OSG said in interview that he did not recall him having his television on loud that evening.
54. The next morning the man was found by the OSG during morning roll check (this is a physical count of the number of prisoners on each wing within a prison). He said in interview that he was sitting on his bed and there was something attached to the wall above his head, but he could not see a ligature. He told our investigator that he, “immediately put the light on, banged the door, no response so I called it as a code blue straightaway”. (A code blue is an emergency response code which indicates that someone has stopped or has restricted breathing.) He also said he remembered that the television was on at normal volume. He did not enter the cell as, “he didn’t know whether he [the man] was faking it...he wasn’t hanging from the ceiling or anything like that...he could easily have been pretending”.
55. He said he then ran to the office, a short distance away, to fetch the self harm response kit and met a SO and an officer at the front gate of the wing. The officer had collected the nurse on his way, because the nurse did not carry keys during the night and it took approximately two to three minutes for them to arrive at the cell. The SO said that he and the officers ran towards the cell and the two officers entered.
56. The SO told our investigator, “I entered the cell immediately quite happy that I had enough people in attendance should it just be a rouse”. He said the officer

cut the ligature immediately while he offered support to the body and head. He attempted to move the man into a position where first aid could be administered, but found that rigor mortis had already set in. Both the SO and officer told my investigator that they were not trained in first aid or cardiopulmonary resuscitation (CPR).

57. The nurse told the investigator that once he had gone into the cell, he checked for signs of life. The nurse recalled that the man, “was cold to touch and there was no pulse...rigor mortis already started setting”. He then asked for an ambulance to be called in order to confirm the death.
58. The SO said that all present left the cell and the door was locked. He said in interview that he then contacted communications and “told them to break out the orders that they have and to call the necessary people, which would mean calling in an ambulance”.
59. An officer stayed outside the cell to keep a running log and ensure no one else entered the cell. According to the gate lodge record, the ambulance arrived at 6.43am and the man was pronounced dead by paramedics at 6.48am.

After the man’s death

60. Staff found two handwritten notes in the man’s cell written to his sister and friend. These letters were made available to our investigator. The letter to his sister started by saying:

“Well h, if you’ve been given this letter I’m sorry but you will already know by now what’s happened to me ... I’ve got nothing to say about why I’m doing what I’m about to do, I’m just writing this because I know you would want me to say a few words before I leave you forever...”

The letter also included the arrangements he wished to be made for his funeral.

In his letter to his friend, he wrote that he was “feeling lousy”, knowing he had put himself in this position, that he was to blame for the way things had turned out and that he did not have, “the strength to keep banging my heart against a brick wall”. He wrote:

“... as I am writing this down I don’t feel scared or upset I feel like for once I can be free, I really know this is going to upset you ... and I’m so so sorry, but I’ve made my mind up now, thank you for everything you’ve done to help me ... we all have to go sometime, I’m just choosing my own time and the way I want to do it ... I’ve nothing left to lose and I’ve got nothing left to give...”

Security intelligence after the man’s death

61. On 20 March 2011, information received by prison security suggested that the man had been given a number of tablets by another prisoner. Two days later, a Security Information Report (SIR) noted that a prisoner told a SO that another prisoner had given, or sold, some pills to him just before lock up on the afternoon

of 19 March. Finally, another prisoner reported that at around 5.00pm that afternoon, he had seen the man approach a prisoner who gave him a quantity of blue tablets from his pocket. This prisoner also reported that the following morning at breakfast he heard two other prisoners say, "... well that fucks that then, we wont get back what he (referring to the man) owes us now".

Staff support

62. All staff were asked by the investigator if they had received appropriate support after the man's death. Staff assured the investigator that they had, including being invited to a hot debrief (a meeting which takes place immediately after a death in custody to discuss any issues).

Prisoner support

63. Three prisoners all said they found out about the man's death when a note was put under their cell doors. Prisoner A said he attended the chapel that morning and lit a candle in his memory. A review of prisoners who were at risk of harming themselves was completed by the Safer Custody group.

Family Liaison

64. The man had listed several individuals as his next of kin. Because of the distance from the prison they were informed of his death by their local police force. The police liaison officer for the prison contacted Surrey Constabulary to ask them to inform the man's sister of her brother's death and they later confirmed they had done. Prison staff opened a Family Liaison Log (this is a list of actions and contacts between the prison and the family) on the morning of 21 March and the family liaison officer also spoke with the man's sister to inform her of his death. She paid a visit to the prison and met with both staff and prisoners who had known her brother.
65. The investigator and his colleague visited the man's friend at home and she described how she first met him when she was a Samaritan and he was a prisoner at HMP Highdown. She trained him to be a Listener (this is a peer support scheme in which Samaritans train prisoners to listen in complete confidence to other prisoners) and remained in contact with him throughout his time at Highdown, Elmley and Swaleside even after he had stopped being a Listener. She said she had visited him about every six weeks and was unaware of him having any other visitors. She said he improved after he moved from Elmley to Swaleside and had never talked about self harm or suicide with her.

Post-mortem examination

66. A post-mortem examination was conducted on 24 March by pathologist, who concluded that the man's death was due to "suspension". A toxicology report confirmed that traces of diazepam were found in his body.

ISSUES

Clinical care

67. The clinical review was conducted by a clinical reviewer and although he does not make any recommendations, he raises points to consider. He concludes that the man's care "... seems to have been appropriate and of a high standard and it seems that everyone has worked hard to support this vulnerable man".
68. However, the clinical reviewer is concerned about the mental health input the man received between March and July 2010, when there was no recorded contact. The report also notes that the man "... seems to have been "lost" on transfer from Elmley to Swaleside", and not seen by the mental health team for four months. This is some time prior to the man's death, and there was no diagnosis of a mental health illness at the time of his death. Nevertheless, we recommend the Governors and Heads of Healthcare should ensure there is a seamless transition of healthcare provision between the cluster prisons.

The Chief Executive Officer, Governor and Head of Healthcare should ensure that sufficiently robust systems are in place to ensure continuity of healthcare for when prisoners are transferred between establishments within the Sheppey cluster.

69. The clinical review recognises, however, that the mental health team are covering large caseloads with no cover at weekends and bank holidays. Although he does not think this, "made any difference to the man's case... a weakness does seem to be highlighted". As this does not appear to have affected his care, we will not be making a recommendation to the Primary Care Trust or the Governor.

The two security reports following the man's death

70. Following the man's death prisoners told staff that he had been seen with blue pills the night before he died. These 'blue pills' could have been the diazepam referred to in the toxicology report. Although the report states there were traces of it in his body, his cause of death was due to suspension. There is no evidence to suggest the diazepam contributed to his death.
71. Two prisoners were overheard making a comment about not getting back what they were owed by the man. The investigator considered whether he was being bullied, asking both staff and prisoners as to how he coped in prison. Although he was angry about his recent sentence, there were no reports of any other concerns with him. No Security Information Reports were submitted before his death, to alert staff to any potential problem. There was no further evidence to suggest he was being bullied in prison.

The assessment of the man's risk

72. On 3 March, the man received a further sentence for the threats to kill offence and was returned to Swaleside. There was no evidence that his risk was reassessed by officers or a nurse on his return from court. Paragraph 4.8 of

Prison Service Order (PSO) 2700, Suicide Prevention and Self Harm Management, requires that “reception or first night staff must talk with prisoners with a change of circumstance, which would include those being sentenced, and record their conversation”. The PSO also recommends that a health screen is completed for all prisoners in such circumstances, although it is not a mandatory requirement.

73. An officer talked with the man on his return from court, knew of his change of circumstances and ensured she and other staff were aware of how he was feeling. However, she could not recall whether she had recorded the conversation during interview, and there was no corresponding entry in his records. There was also no entry in his medical or core records to demonstrate he was assessed on his return from court by a nurse. Although not a mandatory requirement, a health screen would have been another opportunity for staff to discuss his response to his sentence.

The Chief Executive Officer and Governor should ensure all staff carry out the requirements of PSO 2700 intended to safeguard prisoners who have had a change of status at court.

74. The man gave some of his possessions to other prisoners the night before he died. In hindsight, giving away his possessions may have been an indication that he was feeling suicidal. However, prisoners did not think he was at risk at the time and therefore did not bring these interactions to the attention of staff. As staff were not made aware that he had given away his belongings until after his death, they could not reasonably be expected to have acted upon this indication of risk.

Discovery of the man in his cell

75. The OSG immediately raised the alarm when he discovered the man. He was unsure if there was a ligature around his neck and thought he should not enter the cell until there was another member of staff present. At night, all prisoners are locked in their cells and there is a far lower number of officers than during the day. For security reasons, breaking the night state by opening an individual prisoner’s cell can only be done in exceptional circumstances. In this case, the OSG acted in accordance with procedure in Swaleside’s ‘Safer Custody: Suicide Prevention and Self Harm Management Policy’. The policy instructs that staff should only enter the cell if it is safe to do so. It is our opinion that the OSG acted according to the local policy.
76. The officers and healthcare responded immediately to the code blue, however the officers did not have up to date first aid or CPR training. The clinical review states that CPR would not have made a difference to the man. However, all staff should be trained in this to be able to respond if required. It is essential that there are sufficiently trained staff on duty at any time in prison to respond appropriately to medical emergencies. We refer to another letter written on 20 October 2010 to all prison governors. The letter highlights the need for each establishment to review the first aid arrangements for prisoner related incidents and remedy any shortfall.

The Chief Executive Officer and Governor should ensure that sufficient staff are trained in first aid or basic life support.

77. There was a short delay between discovering the man and calling an ambulance. I refer to a letter written jointly to all prison governors and primary care trusts by the Director of Offender Health dated 17 February 2011. This letter states where there are concerns about the immediate health of a prisoner an ambulance should be called without waiting for healthcare staff to attend the scene. A follow up call can be made to cancel the request if healthcare arrive and deem it unnecessary for an ambulance to respond.

The Chief Executive Officer and Governor should ensure all staff are aware of the procedure in relation to calling an ambulance if there are immediate concerns about a prisoner's health.

CONCLUSION

78. The man had medical input from the IDTS team and had successfully completed his detoxification some time prior to his death. His mental health was treated, and his medication was regularly reviewed. As the clinical review states, he did have a high standard of medical care.
79. Shortly before his death, the man was sentenced for a further offence about which he was very unhappy. The evening prior to his death he had given away possessions and made a remark to another prisoner that he intended to get out of prison. His death occurred during the night when he was unlikely to have been disturbed, and two letters were found in his cell suggesting he intended to take his own life. By the time he was discovered in his cell rigor mortis had already set in.
80. The man intended to take his own life and this investigation found no evidence to suggest this could have been prevented by staff at Swaleside.

RECOMMENDATIONS.

1. The Chief Executive Officer, Governor and Head of Healthcare should ensure that sufficiently robust systems are in place to ensure continuity of healthcare for when prisoners are transferred between establishments within the Sheppey cluster.

Accepted – *The Mental Health Team have reviewed their protocol in partnership with the healthcare providers and their policy reflects a daily check on discharges from the establishment each day, in order for mental health practitioners to ensure effective care pathways for their clients.*

2. The Chief Executive Officer and Governor should ensure all staff carry out the requirements of PSO 2700 intended to safeguard prisoners who have had a change of status at court.

Accepted – *A notice to staff has been published along with clear guidelines outlining the requirements of PSO 2700 regarding those prisoners who have a change of status or appeal rejected. The Safer Custody Manager has briefed reception staff.*

3. The Chief Executive Officer and Governor should review the need for first aid or basic life support refresher training for staff on frontline duties.

Accepted – *A review will be conducted to assess the need, type and scale of training required to provide adequate cover within existing resources.*

4. The Chief Executive Officer and Governor should ensure all staff are aware of the procedure in relation to calling an ambulance if there are immediate concerns about a prisoner's health.

Accepted – *The Safer Custody Manager has published a notice to staff outlining the correct procedures for medical emergencies.*