PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man in January 2012 at HMP Wayland

Report by the Prisons and Probation Ombudsman for England and Wales

October 2012

This is the report of an investigation into the death of a man at HMP Wayland in January 2012. He was found hanging in his cell. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer was commissioned to undertake a review of the man's clinical care in custody. Staff at HMP Wayland co-operated fully with the investigation.

Although not apparently related to his death, there was a delay in the man being diagnosed with diabetes, despite reporting relevant symptoms. The clinical reviewer considers this delay would have been unlikely to occur in the community.

The man had been in prison for some years and seemed to be fairly settled. On 17 January 2012, he reported sick and did not attend work. A doctor's appointment was made for the following day. Neither staff nor his friends noted anything unusual in his behaviour through the rest of the day. Sadly, when his cell was unlocked the following morning, he was found to be unresponsive, with a piece of cloth tied round his neck attached to the bed frame. Staff made attempts to resuscitate him, however he was confirmed dead by paramedics shortly afterwards.

The investigation has identified some areas for improvement in health procedures and family liaison. Although one of the officers involved was not carrying an anti-ligature knife, the emergency response was swift and appropriate. I am satisfied that staff at Wayland could not have been expected to foresee or prevent the man's death. I am pleased to note that the National Offender Management Service has accepted the recommendations made.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2012**

CONTENTS

SUMMARY

1. The man had spent a number of years in prison, and was serving his second life sentence. His earliest possible date of release was 2004. Although he had some health problems, he did not suffer from any major illnesses.

2. The man maintained that he was innocent of the offence for which he received his first life sentence, and said he was appealing against that conviction. He also said that he thought that his actions that led to his second sentence were reasonable in the circumstances. Although he participated in some courses earlier in his sentence, he had become increasingly reluctant to engage with any offence related work. This caused problems in progressing through his sentence and moving towards release. Despite this, he was described as a polite man who caused no problems.

3. In July 2010 he was diagnosed with diabetes. After some initial difficulties, he complied with his medication and the diabetes was controlled. He did, though, continue to have problems with his health, and was in frequent contact with healthcare services in the prison.

4. On the morning of 17 January 2012, the man said that he was sick and would not attend work. Wing staff contacted healthcare, who made an appointment for him to see the prison doctor the following day. Through the remainder of the day, neither staff nor the man's friends noticed anything untoward in his behaviour, although he did not go to see the Sikh minister as planned because he still felt unwell. That evening he made a telephone call to his family, said goodnight to his friends and went to his cell.

5. Checks were made on prisoners twice during the night, between 8.30pm and 9.00pm and then again between 5.40am and 6.00am. The member of staff who carried out these checks did not notice anything out of the ordinary when he checked on the man.

6. At approximately 8.20am on the day of the man's death officers began to unlock the prisoners on the wing. On unlocking the man's door, Officer A was unable to open it. He called to the man, but got no response. He switched on the cell light and could see him sitting at the foot of his bed. He called a colleague over but they were still unable to open the door. The officer then called for assistance over the radio, and other staff came to the cell. Eventually, they managed to open the door enough to enter.

7. Once they had gained access, staff found the man sitting on the floor at the foot of his bed. His legs were outstretched in front of him, reaching to the door, and it was this that had made the door difficult to open. He had a piece of cloth tied around his neck, and a cloth in his mouth. Staff cut the ligature and removed the cloth, and began to try to resuscitate him. Medical staff attended and supervised the resuscitation attempts until an ambulance arrived. Paramedics assessed the man, and confirmed that he had died.

8. We endorse and reframe the clinical reviewer's recommendations relating to diabetes care. We make two additional recommendations concerning the requirement for staff to carry anti-ligature knives; and ensuring there is adequate cover of family liaison duties.

THE INVESTIGATION PROCESS

9. This office was informed of the man's death on the day he died. HMP Wayland provided the Ombudsman's investigator with his prison record. The investigator also obtained the his prison medical records. He visited the prison and met the Governor. He also spoke to staff and prisoners who knew the man.

10. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact the investigator. No further information was received.

11. A clinical reviewer was appointed to review the man's clinical care while in prison. The investigator and the clinical reviewer discussed matters throughout the investigation. They also conducted joint interviews of staff. The clinical review is annexed to this report.

12. The investigator formally interviewed nine members of staff and three prisoners. Eleven of those interviews were recorded and transcribed. The other interview was conducted over the telephone and a note of the interview made. The investigator provided verbal feedback to the prison's liaison officer, as well as formal feedback to the Governor at Wayland during the investigation.

13. One of our family liaison officers contacted the man's brother, his listed next of kin, to explain the investigation and offer his family the opportunity to ask any questions or raise any issues. The man's family did not raise any issues at that time. The draft report was provided to the family, and they did not offer any further comment.

14. The investigator wrote to HM Coroner to inform him of the investigation and obtained a copy of the post mortem report. This report will be sent to the Coroner to assist his enquiries.

The Man

15. The man was born in Pakistan. He moved to the UK, with his family, when he was 11 years old. After leaving college, where he studied engineering, he worked as a machine operator. He later worked in the civil service before joining the family business.

16. The man was married and had two sons. He had no reported psychiatric history, and there were no reports of alcohol or drug misuse.

17. In February 1986, the man was convicted of conspiracy to murder and sentenced to life imprisonment. He was released on licence in February 1995. In April 1997, the man made a serious attack on his wife and he also injured his son. He was given a discretionary lifer sentence for this offence with a minimum period to serve of 7 years. This meant his earliest possible date of release was 2004, and at the time of his death he had served nearly eight years more than his minimum term.

HMP WAYLAND

18. HMP Wayland is a category C prison in Norfolk. (Category C is for prisoners not yet ready for open conditions and for whom escape must be difficult, but who do not require high security.) It opened in 1985, and comprises 13 residential units. E wing, where the man lived, is a wing for enhanced (prisoners with good behaviour records) life sentence prisoners.

19. Healthcare is provided by Serco Health. There is nursing cover in the prison between 7.30am and 7.30pm. A local out-of-hours service is used at other times.

Previous deaths at Wayland

20. Since this office took over responsibility for investigating deaths in prison custody in 2004, seven prisoners have died at HMP Wayland (six deaths occurred before the man's death and one since). Five of these deaths were due to natural causes. There are no similarities between these and the man's death.

Her Majesty's Inspectorate of Prisons

21. The last report published on HMP Wayland by HM Chief Inspector of Prisons followed an announced inspection in June 2011. The inspection report found that Wayland was "generally a safe prison", but healthcare was not well managed, and access to the range of health services was inadequate for the needs of the population:

22. The report also noted that GP services were reliant on locum staff. The self-harm and suicide prevention policy was said to be well managed.

Independent Monitoring Board (IMB) report

23. Each prison has an Independent Monitoring Board, made up of unpaid volunteers from the community who are responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained.

24. In their most recent published report in May 2011 Wayland IMB said Wayland "a first rate prison". However, the report was critical of healthcare, and the IMB said health services had been put under extreme pressure because of staff shortages and services had deteriorated since SERCO had been awarded the contract

25. The investigator spoke to the Chair of the IMB. She had no concerns about the man's care or the way staff had responded on the day of his death.

Sentence planning and the Parole Board

26. All life sentence prisoners have a life sentence plan based on an assessment of their risks. The sentence plan should include goals to help reduce identified risk factors such as changing behaviour, programmes to attend and getting help with any drug and alcohol problems. The sentence plan is reviewed regularly and is used to make decisions about any work the prisoner undertakes, and their security category. The Parole Board uses the sentence plan to help assess whether a prisoner has reduced their risk when they apply for parole.

27. The Parole Board for England and Wales is an independent public body. Its role is to make risk assessments about prisoners to decide who may safely be released into the community once they have served the minimum term imposed by the courts.

KEY EVENTS

28. In February 1986, the man was convicted of conspiracy to murder and sentenced to life imprisonment. He was released on licence in February 1995. In October 1997, he was convicted of serious offences and sentenced to life imprisonment with a seven year tariff (the minimum term to be served). In the early years of his sentence he was regarded as having made reasonable progress. In 1999 he completed a victim awareness course, and in 2000 he participated in the Reasoning and Rehabilitation Programme. He had some contact with healthcare services for various minor ailments, dental treatment, and optical treatment. He was a non-drinker and non-smoker, his behaviour and mental state were both reported as good.

29. In June 2007, the man was interviewed by a psychologist. The psychologist noted that although he had completed some group and individual psychological work, the man had failed to engage consistently with interventions. In the courses he had undertaken, he had shown a good level of skills, but had struggled to maintain progress. She said he cast himself as a victim and had a tendency to blame other people or circumstances for events. He blamed the victim of his offence for provoking him and did not appreciate the consequences of his crime. The psychologist noted that, although there were some characteristics of psychopathy, these did not meet the criteria for such a diagnosis. No significant personality disorder was noted, and there was no history or signs of major mental illness.

30. In October 2008, the man transferred to Wayland. Although he continued to have contact with healthcare for various problems, no major health issues were noted.

31. A year after he arrived in Wayland, the Parole Board considered the man's case. They recommended that an up-to-date psychological assessment should be made before they next considered his case.

32. In early 2010 the man saw healthcare staff about problems with his foot and was treated by a podiatrist. A note on his case notes on 23 January indicates that there had been a referral to the mental health team because of a change in his behaviour. From being polite and friendly, he had begun to complain about numerous things. The files do not indicate whether this referral was followed up.

33. In May 2010, the man claimed that he had not been informed of the review of his case by the Parole Board in November and this was the reason he did not appeal the decision. Senior Officer (SO) A made a note on his file that the man held the view that his release was not his problem, rather something the prison would need to deal with. He had read in the press of a prisoner serving a long sentence who had been released, and felt that this should happen to him. SO A said he was adamant that his perspective was correct.

34. A year later, in May 2011, the man was due to have a sentence planning and review board assessment. Reports were therefore collated from staff who knew and worked with him.

35. His personal officer wrote that the man was an enhanced level prisoner (of good behaviour and given certain privileges). He worked in a trusted position, had no adjudications against him, and drug tests proved negative. He was, though, convinced that he was the victim of a miscarriage of justice. He said he was appealing against his first conviction in 1986, and would not engage in any offence-related work.

36. His offender supervisor also wrote that the man denied any involvement in the offence that resulted in his first life sentence. Furthermore, he maintained that he was right to behave the way he did in the incident that led to his second life sentence. While he said he was sorry for the injuries his son sustained, he did not consider the psychological impact. Although honest and co-operative in interview, and willing to work with sentence planning boards, the man refused to engage in offence-focussed work. He also said he had no desire to obtain vocational qualifications. Although his behaviour was good, his stance on offending behaviour work meant that his risk was not reduced. The man's offender supervisor commented that he would need to address this before he could progress further in his sentence.

37. Officer A had updated the man's offender assessment system (OASys) report. He wrote that the man was open and honest in interview. He conducted himself in a mature way, and engaged well. He provided the man with a copy of the assessment report and the man was happy with the contents.

38. Over the weekend of 18-19 June 2011, the man had been unwell. Staff asked healthcare to assess him and Nurse A saw him on 20 June. His medical notes show that he was suffering from the need to urinate frequently and pain when urinating. A test of his urine showed increased glucose levels. He denied reports that he had been physically sick, but said that he did have abdominal pain and was generally unwell. He was treated with antibiotics for a suspected urinary tract infection and the nurse sent a urine sample for further tests, which did not show any abnormalities.

39. In early July, the man again reported the need to pass urine frequently and pain when urinating. He was also feeling tired and had lost weight. Blood and urine tests taken in late June and early July continued to show high levels of glucose, which do not appear to have been acted upon. He was also diagnosed with possible Stage 2 Chronic Kidney Disease (CKD).

40. The man's notes show that on 12 July test results confirmed a diagnosis of type 2 diabetes and he was initially prescribed glicazide (diabetic medication). This was 22 days after he had first shown symptoms of diabetes. The man's diabetic medication was changed to metformin on 19 July.

41. The man's medical record also shows that he had seen a locum doctor and been advised he needed a change of diet to include avocado pears, alfafa

beans and no carbohydrate. The note states that this would not be possible within a prison regime.

42. On 22 July, the man's case notes were updated by his personal officer. The man had been off work recently because of his health, but generally he was punctual. He had a small circle of friends with whom he associated, but was fairly quiet. He continued to refuse to engage in any offending behaviour work, so the risk he presented remained unchanged. The personal officer wrote that the man did not seem to care about being in prison.

43. Over the coming weeks, the man continued to have contact with healthcare to monitor his diabetes and general health. The man continued to complain of painful urination and was prescribed antibiotics. On 20 October, the Parole Board wrote to him, informing him that they had considered his case. The Board did not recommend his release or transfer to open conditions, and listed risk factors as:

- Domestic violence
- Attitude towards women
- Relationships
- Pro-criminal attitude towards his offence
- Inability to make decisions
- Use of a weapon
- Lack of insight into the impact upon victims
- Extremely violent nature.

44. The Board asked to review the case again after two years. This would allow the man to undertake relevant courses and offence-related work.

45. A further OASys assessment was carried out in November. The assessment noted that the man did not express remorse for the attack on his wife. He maintained that, in the circumstances, his actions were reasonable. He said that he was still appealing against his original sentence, and had no intention of participating in any offence-related courses. He had completed a course in 2000, and said that this meant that he did not need any further coursework, unless it could be proved to him that it would benefit him. He said he was happy to remain in the prison environment, where he was financially independent and no burden to his family. His work reports were good and he had a positive work ethic. He associated with a small group of prisoners and kept a working relationship with staff. He had no apparent problems in coping with prison life and there was no evidence of any emotional problems.

46. On 5 December, the man reported to healthcare that he was still suffering pain when urinating, and needed to urinate frequently. He said he had developed a swollen cracked foreskin since commencing metformin. The man said he had stopped taking metformin and the symptoms had got better, so he was reluctant to try it again. Nurse practitioner A discussed the man's symptoms with him and explained that they were probably as a result of the diabetes rather than the medication. The man agreed to recommence metformin.

47. A psychological report, completed on 15 December noted that the man was not willing to engage with the assessment process. Accordingly, he was added to the waiting list for one-to-one psychological work. The same day, he was reviewed by a nurse and his medication updated.

48. On 10 January 2012, a friend of the man's said that during the night he had heard screams coming from what he thought was the man's cell. The following morning he asked the man if it had been him. The man said that he had not.

49. Having failed to attend work on 16 January, Officer B issued the man with a warning. The following morning he told staff that he felt unwell and would not attend work. At approximately 9.00am he pressed his cell bell, and Officer C went to see what he wanted. He told the officer that he had blood in his stools, which was a part of his ongoing health issues, and he wanted to speak to a member of healthcare staff. The officer informed the wing co-ordinator and then telephoned healthcare. He explained what the man had told him and an appointment was made for him to see the prison doctor the following morning. The officer fed this back to the man, who he said thanked him, and said he was content with this. He spoke politely and the officer noted no indication of any concern or anxiety.

50. At lunchtime, the man spoke to a friend of his. He told his friend that as he was unwell, he would not be going to see the Sikh minister that afternoon, as he usually did. The friend asked him what was wrong, and the man gestured the length of his body with his hands, and said "all over". The friend understood the man to mean that he did not want to discuss his health and did not prolong the conversation.

51. At approximately 5.00pm, Officer C unlocked the man's door for association (free time when prisoners can socialise with each other). He did not notice anything out of the ordinary, either then or when he saw him during the association period. During association the man spoke to a fellow prisoner. He mentioned his health problems and the fellow prisoner thought that he was a little down about this, but without showing any signs of anything deeper. During the evening the man made a telephone call to his brother and spoke to various family members, some of whom mentioned that he sounded a little down. The man mentioned some problems with his health and that he had found blood in his stools and urine, but did not mention any other concerns.

52. Shortly before prisoners were locked up, the man went to the cell of a close friend. The man talked about his health problems, saying that he had been passing blood and was waiting to hear from the doctor. He said goodnight, and left. The man's close friend did not notice anything unusual in the man's demeanour.

53. At 6.30pm prisoners went back to their cells and were locked in for the night. Officer C locked the man's door and, although they did not speak, the officer saw no indication of any problems.

54. An Officer Support Grade (OSG) was working on E wing that night. He took over from day staff and shortly before 9.00pm conducted a roll check of the wing. (Roll checks are to ensure that the correct number of prisoners are present in the prison.) In interview, the OSG said that during a roll check, he would look through the observation panel into each cell and ensure that he detected movement or sound from each prisoner. He did not know the man and did not remember seeing him that evening. The OSG was clear that this meant that he looked into the man's cell and there was nothing noteworthy about what he saw.

55. There were no issues during the night and no calls on the cell bell system. The OSG conducted a further roll check shortly before going off duty the following morning, just before 6.00am. Again, the OSG said in interview that he ensured he noted sound or movement from each prisoner. Once more, he did not recall anything unusual about the man's cell.

56. The prisoner who was in the cell next to the man. He later said that during the night of 17-18 January he was awoken by a loud bang from the man's cell. He had no idea, though, what time this was.

57. Officer A went to unlock the man's cell at 8.20am on the day the man died, but when he unlocked and opened the door it moved only a very small distance then sprang back closed. The officer called for the man to move the blockage, but got no response. He turned on the cell light and called to Officer D, who was opening cell doors on the same landing, for assistance. He looked into the cell and could see that it was he man blocking the door. He called for immediate assistance over his radio. At this stage he could not see that the man had a cloth tied around his neck.

58. Officers A and D tried to open the door, but were unable to do so. Officers C and Officer B joined them, as did a fellow prisoner who had been unlocked, and SO A. They were still unable to gain entry. Having heard the call for assistance, Officer F arrived and, at this point, the fellow prisoner returned to his cell. The few prisoners who had been unlocked were returned to their cells. Officer F added his weight to the efforts to open the door and managed to force a big enough gap to get in.

59. Once in the cell, Officer F could see that the man had a white cloth in his mouth, and a t-shirt tied around his neck, attached to the bedframe. There was no sign of a disturbance in the cell. Officer F moved the man's legs and opened the door, allowing Officer D and SO A to enter. He asked Officer D for his anti-ligature knife and cut the cloth from the man's neck. He also removed the cloth from his mouth. The officers then laid the man on the floor and began attempts at cardiopulmonary resuscitation (CPR – a mix of compressions and rescue breaths delivered in an effort to maintain the oxygen flow around the body). Officer F was first aid trained (although his training had expired) and performed chest compressions and SO A (a first aid officer) carried out rescue breaths (formerly known as mouth-to-mouth) using a mouthshield. Officer A collected a defibrillator (a machine that detects

rhythms in the heart and, if detected, applies electrical impulses to stimulate the heart to regain a normal beat). The officers noted that the man was cold to the touch, his right arm was raised and stiff and his face, which was pale with a slightly blue tinge, was rigid and slightly contorted.

60. At 8.23am SO B called the communications room and requested an ambulance. Nurse A was the member of healthcare staff responsible for responding to emergency calls that day. Having heard the radio call for assistance, she went to E wing, arriving at 8.24am. She was not aware of the nature of the emergency until she arrived. She found Officer F and SO A performing CPR and, having confirmed that an ambulance had been called, Nurse A offered to take over. Both staff said they wanted to continue so, ensuring that they were doing so correctly, Nurse A remained and supervised. She noted that the man's chest rose and fell with each rescue breath, showing that his airway was clear. He had no signs of any injury on him. She and Officer F applied a defibrillator to the man, but the machine could not detect any activity in his heart so staff continued with CPR. Nurse F did not detect any signs of life from the man, and remained in the cell with staff performing CPR until paramedics arrived.

61. The ambulance arrived at the prison at 8.36am and paramedics entered the man's cell at 8.41am, after Nurse A had briefed them. They asked SO A and Officer F to stop CPR to allow them to assess the man. They were unable to find any signs of life and, at 8.43am, they confirmed that the man had died.

Informing the man's family

62. At the time, Wayland only had one trained family liaison officer (FLO). That morning, the FLO was on a course in Surrey. When he was informed that he had been appointed as FLO, he had to return to Wayland, collect the necessary papers, change his clothes and then, with a colleague, travel to the family's address in Middlesex. He arrived there at 4.20pm. Unfortunately, by this time the family were already aware that the man had died. This was because the prison had held a memorial service for the man earlier in the afternoon. After the service a prisoner had told a member of his own family on the telephone who, in turn, had told the man's family before the FLO reached them.

Debrief and support for staff

63. After a death, prison managers must hold a "hot debrief". This is a meeting of all the staff who were involved in finding and attempting to resuscitate the prisoner. The meeting should focus on reassurance, information sharing and how staff can support each other.

64. A debrief was held on the wing that day. The staff care team were present, as were representatives from the chaplaincy and the management team. Staff were reminded of the support available to them. The following day, four members of staff were given an informal debrief by a member of the prison's

psychology team. Notices posted in the prison, informed other staff that the man had died.

Informing prisoners

65. Prisoners on the wing were kept locked in their cells throughout the morning of the 18 January. Staff explained to them that there had been an emergency. Prisoners were subsequently informed of the man's death through a notice issued later that day. Sikh prisoners were informed personally by the chaplaincy.

66. Through the rest of the day, the regime on E wing was relaxed to accommodate prisoners' periods of exercise and association, and prisoners were offered a choice of attending work or not. A visible officer and chaplaincy presence was maintained on the wing. All prisoners who were subject to special support measures for those at risk of harming themselves had their circumstances reviewed.

67. Staff ensured that the prisoner who had helped staff at the man's cell door was spoken to personally after his involvement in what had happened. SO B went to see him, checked on his wellbeing, and thanked him for his assistance that morning. He offered the opportunity to speak to a Listener (prisoners trained by the Samaritans), or to move into a cell with someone else for company, which he declined.

Post Mortem

68. A post mortem was carried out on 24 January 2012. The report concluded that the man's death was due to hanging.

Funeral

69. The man's funeral was held on 14 February 2012 at Earlham Crematorium in Norwich. The prison were represented at the funeral and in line with national guidance, contributed to the cost.

Internal healthcare review

70. The Nurse Practitioner Service, responsible for primary healthcare in the prison, is provided to HMP Wayland by Horizon Health. Following the man's death, Horizon Health conducted an internal review of his care. The review identified that earlier recognition of the signs and symptoms of diabetes would have benefited the man. The review also noted that the man's diabetes should have been monitored more frequently. In addition, the review acknowledged that, although the man did not appear to be depressed, staff should have considered the issue when it was noted that the man was not complying with his medication.

ISSUES

The man's sentence progression

71. We have considered whether the man's failure to progress through his sentence affected his state of mind. The man persistently refused to engage in any offence-related work. This refusal was seen as a barrier to his progression through his sentence and his eventual release, as he was not seen to have reduced his risk of reoffending. The investigator raised this issue with a number of staff and prisoners, to try to establish whether the man understood the consequences of his stance.

72. Everyone said that in their opinion, the man was clear on the results of his refusal to engage. His personal officer explained it to him a number of times. His friends said that he had spent a number of years in prison and was experienced in both participating in and observing the parole process and they did not think it plausible that he did not understand.

73. The investigator was unable to interview the man's offender supervisor from the probation service. However he was given access to her notes and spoke to her colleague. He confirmed that on 10 March 2010 the man attended a sentence planning meeting where the consequences of his refusal to engage in offence-related work were discussed. The man said that he was aware that this was impeding his progression, but he would not alter his stance. At a further meeting on 20 April 2011, it was recorded that the man had not changed his point of view. In light of this meeting, staff contacted the psychology department for further assessment. (The Psychology Department subsequently concluded that further assessment was not required.) The colleague confirmed that the man presented as calm and reasoned when discussing his position and there was nothing in his demeanour that indicated that he did not understand the situation.

74. We understand that the man refused to engage in offender-related work because he did not believe he was an offender. He said he was appealing against his original sentence and did not believe he was at fault for the offence leading to his current sentence. It was a stance he was clear on and was prepared to take. The man had no history of mental illness and there was no evidence that he was displaying any signs of being mentally unwell. It seems reasonable, therefore, for the prison to accept that the man understood that by refusing to engage in offence-related work, he was jeopardising further progress in his sentence. Nevertheless, staff persisted in trying to engage with him. Had he chosen to do so, he would have been able to attend the relevant courses.

75. The investigator has noted that there were reports in the press on 17 January about a European Court of Human Rights ruling on prisoners serving life sentences in the UK. The Court had ruled that it was not unlawful for some prisoners to be expected to spend the rest of their lives in prison. This ruling specifically referred to prisoners serving indeterminate sentences, who had been given whole life tariffs (the amount of time they were expected to spend

in prison). The man did not fall into this category (his tariff had expired), but his continuing refusal to engage in offence related work and accept responsibility for his offence made it difficult for him to convince the Parole Board that he had reduced his risk and was suitable for release. There is no evidence that he mentioned this either to staff or fellow prisoners, and he did not refer to it in his telephone call to his family. This may be entirely coincidental and it is not possible to say whether the man was concerned about the ruling, but it is possible it was on his mind.

The man's healthcare

76. The standard of the man's healthcare is dealt with extensively in the clinical review. The clinical reviewer believes the man's diabetes was not diagnosed as quickly as it might have been. Had he been in the community and presented with symptoms of frequent urination, tiredness and glucose in his urine, this would have triggered further blood tests, an earlier diagnosis, a referral to a dietician and a referral for eye screening. There would have been assessments, including blood pressure and kidney function. This did not happen. Additionally, the clinical reviewer points out that the man had been diagnosed with possible Stage 2 chronic kidney disease and states that the treatment for this would require extra care to monitor blood pressure and blood sugar levels.

77. After he was diagnosed with diabetes, the man was seen by a locum doctor and given inappropriate advice on the changes he would need to make to his diet. The investigator and the clinical reviewer raised this with healthcare staff. It appears clear that staff recognised that the advice was not correct and the difficulty in obtaining specific foods for the suggested diet is noted in the man's medical record. However, we are satisfied that Wayland does provide proper therapeutic diets for prisoners with diabetes.

78. The clinical reviewer notes that Horizon Health (a subcontractor of Serco) carried out an internal review of the man's care. The outcome of the review concurs with the clinical reviewer's report. The report notes that some patients diagnosed with long term conditions often experience depression. While there is no evidence that this occurred with the man, the clinical reviewer (and Horizon Health) make the point that the issue of depression should have been considered by healthcare staff, especially when it was noticed that the man was not complying with his medication.

79. The clinical reviewer makes a number of linked recommendations in relation to diabetes care and record keeping at Wayland, which we endorse and have reframed as follows:

The Head of Healthcare should ensure that patients with diabetes (or any chronic condition) are monitored according to appropriate protocols (in accordance with NHS and NICE guidelines).

The Head of Healthcare should ensure that all relevant healthcare staff are appropriately trained to understand the signs and symptoms of diabetes within at risk patient groups.

The man's demeanour in the time leading up to his death

80. Neither staff nor prisoners noted any change in the man's demeanour or behaviour in the period leading up to his death. The man's personal officer had been his personal officer for over a year and knew him reasonably well. She noted that over the previous month he had been his normal, polite and respectful self. The only change had been that he had not attended work on some occasions because of his health. Officer G supervised the man at work for over two years. Again, the only change he noted was occasional non-attendance for health reasons. He saw no sign of the man being depressed or low in mood.

81. The prisoner in the cell next to the man said that during the night he died, he heard a noise from the man's cell. He described the noise as a bang but was unable to say what time this was. It is not possible to draw any conclusion from what he might have heard. The investigator also interviewed three of the man's friends on the wing, all of whom had seen and spoken to him the previous day. Although they mentioned that he was a bit down over his health, none of them had any concerns that he might seek to harm himself or take his own life.

82. On the evening of 17 January, the man made a phone call to members of his family. He spoke to a number of people. One asked if he was okay, as he sounded upset. Another asked him if he was okay and the man said that he was not too bad, "fair to good". He mentioned his health problems and the relative told him to remain positive. The rest of the phone call was general conversation and the man did not sound upset or concerned.

83. It seems reasonable therefore, that staff could not have anticipated the man's actions.

Response on the morning of the man's death

84. The OSG conducted a roll check of E wing late on 17 January and again shortly before 6.00am on the day of the man's death. Although he did not know the man, or remember specifically looking into his cell, the OSG said that he always checked for signs of life from each prisoner. He said that the fact that he did not recall anything about the man was an indication that there was nothing unusual to note. The OSG said that he would have noticed a prisoner sitting on the floor, which was the position the man was found in when unlocked.

85. When Officer A found the door to the man's cell blocked, he called to the man to remove the blockage. When this did not happen, he called and radioed for immediate assistance. Other staff were quickly with him.

86. When calling for assistance, Officer A did not use a code to indicate that it was a medical emergency because at that stage it was not apparent why he could not get into the cell. Although staff responding to the call, including Nurse A, therefore did not know what they were going to face, the emergency response was swift and the nurse brought an emergency response bag with her. There was a defibrillator on the wing.

87. When Officer F entered the cell he did not know what situation he was facing. When he found the man with the cloth around his neck, he did not have an anti-ligature knife with him. The officer responded to a call for assistance immediately and once the situation became clear, he performed CPR on the man, declining the offer from a nurse to take over from him. The officer's actions that morning were a credit to him and it appears that he could have done no more to help the man. He obtained an anti-ligature knife from a colleague immediately, and there was no delay in cutting the cloth from the man's neck. However, staff who have contact with prisoners should be issued with, and carry, an anti-ligature knife at all times. It appears that the officer had not been supplied with a knife, which is a Prison Service requirement.

The Governor should ensure that all staff are issued with, and carry, anti-ligature knives at all times.

88. Once staff had access to the cell, attempts at resuscitation began without delay. CPR was started immediately, by trained staff (although Officer F's training had expired) and a defibrillator was used. A nurse was on hand quickly, and once staff had made it clear that they wished to continue the CPR, she supervised and ensured it was carried out properly. The clinical reviewer comments that staff should be commended for their prompt action in attempting to revive the man and we agree.

Informing the man's family

89. It is unfortunate that the man's family learned of his death before the prison had informed them officially. Guidance in Prison Service Order 2710 (replaced by PSI 64/2011) is that it is preferable for the news to be relayed in person. However, the only trained family liaison officer needed to travel from Surrey, back to the prison in Norfolk, and then to the family home in Middlesex in order to do so. By this time, they had already heard what had happened from another source. We consider that it took too long to inform the man's family, especially when the family liaison officer was not far away at the time. It is not clear to us that it was entirely necessary for him to return to Norfolk first. It would have been more expedient for him to have been met and briefed by a colleague. The Prison Service guidance says that a visit to inform a family should not be unduly delayed by gathering information first.

90. Wayland are in the process of training another member of staff to perform family liaison duties and we are pleased that this is happening. Nevertheless, the Governor should be satisfied that there is enough cover to perform family liaison duties at any time.

The Governor should ensure that there are sufficient trained family liaison officers, so that families are informed of deaths in custody as soon as possible.

91. The FLO established a good relationship with the family despite the initial delay in informing them. Having arranged the funeral at the family's request, he attended, with their permission. He subsequently returned the man's ashes to them. The man's family later sent a card to thank him.

CONCLUSION

92. The man had spent many years in prison. He was well-liked by prisoners and was always noted by staff to be polite and helpful, but continued to hold the view that he should not be in prison. He would not carry out any offence-related work. Staff tried repeatedly to get him to engage but without success. It appeared that he understood this would jeopardise his possible future release.

93. In the summer of 2011, despite the man presenting symptoms of diabetes to healthcare staff, it took 22 days for a diagnosis to be made. The man continued to have health related problems and regular contact with healthcare until his death. Because of the problems around the man being diagnosed with diabetes and the care he received, the clinical reviewer states that the clinical care the man received was below that he could have expected in the community.

94. When staff found the man, he was quickly cut down and CPR commenced. Paramedics attended and confirmed he had died. We are satisfied that everything possible was done by prison and healthcare staff to try to revive the man. His death could not have been foreseen.

95. A lack of trained family liaison officers led to a delay in the man's family being notified by the prison of his death and, regrettably, they were informed by another source. Subsequently, the prison's family liaison officer formed a good relationship with the family and supported them effectively.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that patients with diabetes (or any chronic condition) are monitored according to appropriate protocols (in accordance with NHS and NICE guidelines).

   NOMS accepted this recommendation, commenting:

   - the long-term conditions register would be updated;
   - all relevant patients will be added to the register through the reception screening;
   - annual checks will be completed against national standards.

2. The Head of Healthcare should ensure that all relevant healthcare staff are appropriately trained to understand the signs and symptoms of diabetes within at risk patient groups.

   This recommendation was accepted, noting:

   - the diabetic link nurse would attend update training;
   - training of other staff will be led by the link nurse;
   - Well Man clinics will be re-established, linked with the Nurse Practitioner Service.

3. The Governor should ensure that all staff are issued with, and carry, anti-ligature knives at all times.

   This recommendation was also accepted. All staff were to be contacted to ensure they had a knife issued to them, and any necessary remedial action would be taken. Regular management checks will be undertaken to ensure compliance.

4. The Governor should ensure that there are sufficient trained family liaison officers, so that families are informed of deaths in custody as soon as possible.

   This recommendation was accepted. Action was underway to identify a new candidate for training to replace a forthcoming vacancy.