Investigation into the circumstances surrounding the death of a prisoner at HMP Gloucester, in June 2005

Prisons and Probation Ombudsman for England and Wales

October 2005

This is the report of an investigation into the death of a man who died on 3 June 2005 in hospital. The man was a prisoner at HMP Gloucester and had been found, earlier that morning, hanging from the window bars of his cell.

I offer my sincere condolences to the man's family. The difficulties that families face in coping with a family member who is addicted to drugs need little elucidation from me.

I also offer my sympathies to management and staff at Gloucester prison. They have to work under difficult circumstances with large numbers of very vulnerable men who, in the great majority of cases, are withdrawing from drugs.

Two staff from my office conducted the investigation.

I am grateful for the assistance they received from the staff and management of HMP Gloucester. I wish to acknowledge too the help of the Gloucestershire Police who carried out their own enquiry into the man's death and readily shared information. My thanks also go to West Gloucester Primary Care Trust who conducted the clinical review.

What caused the man apparently to take his own life cannot be known with any certainty. However, there is no doubt that he did not want to be in a prison in England and felt isolated from his family in Wales

Stephen Shaw CBE
Prisons and Probation Ombudsman **October 2005**

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Summary

This is the report of an investigation into the death of a man. The man was aged 37 when he died at 8.30am on 3 June 2005 in Gloucester Royal Hospital. Although from Wales, he was a prisoner at HMP Gloucester and had been found hanging from the window bars of his cell earlier that morning.

The investigation team reviewed the man's prison records and interviewed both prison staff and prisoners. A report has been prepared by West Gloucester PCT on clinical matters.

The man had been at Gloucester since 26 April 2005, having been charged with supplying a Class A drug. This was not the first time he had been in prison. He was considered to be at risk of suicide when he died, and had been in a double cell.

During the reception procedure, the man disclosed his drug habit and that he was a diabetic. He claimed that the only illegal drug he misused was heroin. The man said that he had never attempted self-harm or suicide.

The man spent most of his time located on B wing with another prisoner who was also from Wales. On 10 April, one of the man's relatives told the prison that he was upset. Following an assessment, an F2052SH was opened (documentation for recording the monitoring, care and support of prisoners identified as being at increased risk of suicide/self-injury). The main issue affecting the man was the distance he was from his family, and that it would be very unlikely that he would receive a visit from his mother whilst in Gloucester.

On 1 June, the man was frustrated and abusive to the person serving the evening meal, as he was refused a pudding due to his diabetes. On 2 June, the man was again refused a pudding. This time he threw his tray of food in the direction of staff. He was placed on a disciplinary charge for this.

That night, the man was laughing and chatty with his cell-mate. The night patrol last spoke to him on the morning of 3 June, at around 2:00am, and last saw him apparently asleep in bed at 6:20am. At 7.20am, during a routine F2052SH check, the man was found hanging from the bars of his cell window. Attempts to resuscitate the man were made. Actions taken by staff following the discovery of the man hanging in his cell are described in detail within the report. All staff concerned reacted quickly and made every effort to revive the man. He was subsequently taken to the hospital, but died at 8.30am.

This report focusses on the man's time in prison custody and evaluates the systems in place to establish whether they were (and are) fully effective.

The report makes seven recommendations.

Investigation Outline

The investigation into the man's death was conducted by two of my investigators. They visited the HMP Gloucester and were shown the places where the man would have been, including the reception and induction areas, the healthcare unit and the wings on which the man was located.

They issued a notice to staff and prisoners inviting anyone with information relating to the man's death to make themselves known to the investigation team.

My investigators also spoke to the Chair of the Independent Monitoring Board (IMB), the Prison Officers' Association (POA), one of the prison chaplains, and various other members of staff, including the Safer Custody Manager. They also spoke the prisoner who shared a cell with the man.

My investigators formally interviewed seven prison staff who was involved in the events surrounding the man's death.

The prison gave my investigators full access to all the documentation concerning the man's time in prison. The police also provided copies of the documents and statements in their possession. My investigators obtained some further information from the probation and court services.

One of my investigators and one of my Family Liaison Officers visited the man's mother, to discuss her concerns about what had happened to her son.

Finally, West Gloucester Primary Care Trust undertook a clinical audit of the man's care while in prison.

Background

The man

The man was born on 10 January 1967 in Wales, making him 37 years old when he died. He was one of three boys and came from a close, supportive family. During his imprisonment, contact was maintained with family members by telephone and letter. Due to distance and mobility problems, his mother was unable to visit him in Gloucester and his brothers were at the time prisoners in a Welsh prison.

The man grew up in Mid Glamorgan. At the time of his arrest, he lived with his mother who was also his named next of kin. He had a daughter from a former relationship. The man was described as a quiet, solitary character that would spend a lot of time at home. He was unemployed at the time of his arrest.

The man was an insulin dependent diabetic, and on occasions required treatment in hospital. He was described as suffering from bouts of depression, during which he would sometimes refuse to take his medication or eat appropriately.

This was not the man's first time in prison. He had a number of convictions - for a range of offences that included the supply of drugs - dating from 1983. The man also used heroin.

On 26 April 2005, the man was arrested at his home as part of a large scale police operation in the area. He was later charged with the supply of a class 'A' drug and appeared at the Magistrates' Court where he was remanded in custody awaiting trial. From the Court he was taken to HMP Gloucester.

Gloucester Prison

HMP Gloucester opened in 1782. Modifications and additions, most recently in 1971 when a new wing was added, have enlarged and improved the prison which provides good conditions and training programmes for prisoners. A total of 320 prisoners can be held there.

Three prisoners, two of whom were unconvicted, died within an 18 day period in February 2004, all by hanging. Inquests on all three prisoners have been held, and in each case the jury returned verdicts of suicide. No blame was attached to the prison. There were two further apparently self inflicted deaths in February and April 2005. Both are awaiting inquests. None of these deaths appears to raise issues that are relevant to the man's death.

HM Chief Inspector of Prisons and the Prison Service's Standards Audit Unit (SAU) inspected separately but around the same time in November/December 2003. Both reports identified Gloucester's performance as patchy. SAU identified as unacceptable the programme of induction for prisoners. They re-audited selectively in December 2004. Although the induction programme

was not re-audited, the Governor had by that time completely redesigned the programme and increased its duration to five days. He is confident that, if an audit were conducted now, it would find the induction arrangements for prisoners to be comprehensive and of a high standard.

My investigators examined the induction programme and agree it is comprehensive and well put together. Unfortunately, it has no formal activity at the weekend. This is mitigated in that prisoners who arrive during the weekend are given immediate access to telephones, provided with full induction information and given special pastoral attention by wing staff, prior to joining the formal programme on the Monday.

The Chair of the Independent Monitoring Board told my investigators that Gloucester had learned valuable lessons from the deaths in 2004 and had 'put tremendous work' into revitalising the whole programme of suicide and self-harm arrangements. Personal care by staff was in his view of the highest standard, and documentation had been refreshed in order to provide an audit trail which could be easily followed when staff handed over from one shift to another. His only reservation was that the induction programme did not operate formally at weekends, although he was aware of the intensive support provided during weekends by the chaplain and wing staff.

My investigators reviewed Safer Custody practice at Gloucester and found that Prison Service requirements were met and often exceeded. Staff were aware of the F2052SH system (which is designed to help prisoners at risk of self-harm or suicide) and of the need to act quickly should they suspect any prisoner might be thinking of self harm. Gloucester averages two or three open F2052SH cases daily.

Information is displayed in all areas of the prison and includes details of how staff can help prisoners. The Listeners scheme is also explained. (This is an arrangement where prisoners who have problems, but feel unable to talk to staff, can talk to other prisoners who have been specially chosen and trained by the Samaritans.) There is also comprehensive written information on how to contact the Samaritans. The telephone booths on the wings have the Samaritans message and free phone number displayed prominently.

The Safer Custody Group meets every two months. It is chaired by the head of residence (a governor grade) and attended by staff and Listeners. Suicide Awareness is a standing agenda item, as are Listeners' reports and examination of F2052SH (self harm) statistics. The meeting is well attended but there is one regular notable absentee, the representative of the escort and custody contractor (Reliance) who has not attended for many months. Successive meetings have noted this and attempted to secure the attendance of a representative, but no one has attended since May 2004. This is said to be because of staff shortages.

In addition to this meeting, the Governor chairs a bi-monthly Suicide Prevention Meeting, which reflects the importance that the Governor places on suicide prevention.

Suicide and Self Harm Procedures

Prison Service suicide and self-harm procedures are set out in Prison Service Order (PSO) 2700.

In relation to the processing of an F2052SH, the Order says that when an F2052SH is opened, the manager of the unit where the prisoner resides must:

- Decide, in consultation with healthcare staff, whether to manage the prisoner on the residential unit or refer initially to the Healthcare Centre (HCC), and document the reasons.
- Ensure that, where available, prisoners on an open F2052SH have been offered the opportunity to talk to a Listener and/or Samaritan.
- Ensure a case review is held within 72 hours, and document a summary of the review and agreed support plan.

When a F2052SH is raised by non-healthcare staff, a doctor, nurse or heath care manager must check the prisoner's Inmate Medical Record (IMR), and record in it the raising of the F2052SH.

A healthcare officer or nurse must interview the prisoner as soon as possible. The prisoner must also be referred to a doctor as soon as possible and in any event within 24 hours of any referral to the HCC. A record of these assessments must be made in the F2052SH and in the IMR.

A support plan must be drawn up and agreed. Multi-disciplinary case reviews must be held as necessary, including in the event of a further act of self-harm.

The F2052SH will be closed at a case review when the prisoner appears to be coping satisfactorily. The case review will agree after-care or follow-up requirements.

Follow-up to deaths in custody

PSO 2710 gives instructions on action to be taken following a death in custody, including the support arrangements for staff and prisoners.

The PSO says that priority must be given to communicating the facts about the death to prisoners and staff. It says it may be useful to issue a written statement to prisoners to defuse rumour and myth, but that this will depend on local judgement. Any prisoner who may have been particularly affected by the death should be offered support.

A record should be kept of all those entering where the prisoner died. There should be an immediate post-incident debrief (a 'hot debrief') of staff involved before they go off duty. A senior member of staff should act as a de-briefer and a duty care team member identified and, if necessary, called in on duty. (PSO 2710, Chapter 5.)

Gloucester's local suicide prevention strategy document

In November 2004, Gloucester agreed its local suicide prevention strategy. It sets out the role of the Safer Custody Committee and arrangements for dealing with prisoners at risk.

The local policy says that it is the responsibility of the HCC staff to ensure that, following the opening of a F2052SH, where a prisoner is not admitted to the HCC the doctor should see the prisoner within 24 hours. The process is that newly opened F2052SH prisoners are placed on the day's sick list for the doctor.

Once an F2052SH is opened, a case conference must take place within 72 hours. The local policy requires the review to be chaired by a Wing Manager but does not specify the staff who must attend.

Once raised, an F2052SH can only be closed following a multi-disciplinary case review. Although not specifically mentioned in the local policy, Gloucester operates a F2052SH review board each Wednesday when all open F2052SH cases are reviewed. Representatives from most departments in the prison either attend, or submit a contribution form, which the board considers. The prisoner is invited to attend, or to submit a contribution form should he not wish to attend the board.

Additionally, the local policy requires the Wing Manager to conduct a multi-disciplinary review following all incidents of self-harm.

The policy dictates the frequency that prisoners should be observed, dependent on the assessed level of risk:

- **Level One** – to be observed constantly. Authorised by the doctor or a nurse, or the duty Governor, in consultation with the doctor or a nurse.
- **Level Two** – to be observed randomly five times every hour. Authorised by the doctor or a nurse, or the duty Governor, in consultation with the doctor or a nurse.
- **Level Three** – this is the normal level of observation for prisoners on a F2052SH. To be observed:

    - at first unlock,
    - during the morning,
    - during the afternoon,
    - during the evening,
    - by the night patrol on taking over the roll,
    - at a time between 10:00pm and midnight,
    - at a time between midnight and 2:00am,
    - at a time between 2:00am and 4:00am,
    - at a time between 4:00am and 6:00am,
    - and again at the night patrol's morning roll check.

Chronology of Events

26 April 2005 to 2 June 2005

On 26 April 2005, the man appeared before the Magistrates' Court charged with supplying a Class A drug. At 4:55pm, the Magistrates remanded the man in custody until 3 May when he would appear before the court via video link. The Prisoner Escort Record was completed by the police and warned receiving agencies to be aware that the man had a history of violence and weapons. It also warned that the man had a mental condition. The police told my investigators that this was a mistake, and should have indicated his medical condition of diabetes. Prisoners remanded from this court normally go to HMP Cardiff or HMP Swansea. However, as is a regular occurrence, both prisons were full and the man was therefore taken to Gloucester.

He arrived at Gloucester at 7:00pm. On arrival, the man told staff that he had been living at his home address with his mother whom he named as his next of kin.

The man was given a Healthcare Screening in Reception where he said that he had no physical or mental concerns. He disclosed his heroin habit and that he was a diabetic. He claimed that the only illegal drug he misused was heroin which he said he last used on 25 April. The man said that he had never attempted self-harm or suicide.

The man was assessed as being of "low risk", which means he was deemed suitable to share a cell with other prisoners. He attended the Diabetic Clinic, and then completed the first night induction where his immediate needs were discussed, including an explanation of how to access the Listeners and Samaritans. He was then located in cell A1 – 11.

On 27 April, the man started the five day induction programme. A review of the cell share risk assessment was completed and the man remained a low risk. No problems were identified at that time. The doctor prescribed a 12 day detoxification using Diazepam, and a 10 day detoxification programme using Dihydrocodeine Modified Release tablets. The doctor wrote to the catering staff and authorised a diabetic diet.

On 1 May at 2:00am, the man asked to see the night medical staff. His blood sugar levels were identified as being low and he was given tea and biscuits. He was reviewed later that day by the healthcare staff. On 3 May, the man moved to cell B3 – 01, with a cell mate who was also from the Swansea area.

On 8 May, the man refused his insulin as he was feeling sick. This was eventually given. The man had finished the detoxification programme, but attempted to persuade healthcare to prescribe a further detoxification programme which was denied. On 9 May, the man's cell mate was released from prison on bail.

On 10 May, a relative telephoned the prison and said that the man had told them to say "goodbye to the kids" during a telephone call. An officer followed up this information and interviewed the man at 2:50pm and opened a F2052SH. The man

was tearful and concerned about the distance that his elderly mother would have to travel in order to visit him. His mother's proposed journey was over 50 miles by road, but as she did not drive it was a difficult journey using public transport, which would involve a number changes. This probably meant that he would receive no visits and he wanted to be transferred to Swansea prison, or at least to another Welsh prison.

A nurse reviewed him and in conjunction with the orderly officer, they decided to manage the man on the wing rather than in the healthcare centre. The nurse advised "Frequent but irregular obs 3:1", which in practice appears to have meant "level 3", as described in the local policy. At 5:00pm, the man appeared content. the man was not assessed by a doctor. Another Welsh prisoner, with similar background and circumstances, was found for the man to share a cell with.

On 11 May, the man appeared to be a little quiet but said that he was alright. On 12 May, the man told the officer who opened the F2052SH that he was better and appeared to be quite calm.

Two omissions in the F2052SH procedures followed in the man's case were highlighted in a routine management check on 15 May:

1. When a F2052SH is opened, and the prisoner is not referred to the HCC, a doctor must assess the prisoner within 24 hours.

2. A F2052SH must be case reviewed by a multi-disciplinary team within 72 hours.

Despite these findings, no remedial action was taken.

Additionally, the check commented on the fact that a "Discharge Report" was not completed on page 6 of the document. This was not in fact required, as the man had not been admitted to healthcare.

On 16 May, the man saw a doctor who said that the man's mental health would benefit from a move to a prison nearer his family. He was described as being very flat in mood. This appointment was not related to the missed assessment above.

On 17 May, the man was said to be in good spirits and cracked a joke with staff. He made a formal application to return to Wales, but was told that the Welsh prisons were full. In addition, as he was remanded under the video link system, the courts did not require him to re-appear in person in Wales until his trial. The prison planned to transfer the man nearer the date of his trial.

On 18 May, the F2052SH was case reviewed. The man chose not to attend the review board. The board concluded that the document should be kept open so that staff could "keep an eye" on the man a bit longer. Whilst the review was multi-disciplinary, the record is brief with only a basic support plan. However, a more detailed account of the review was published in a document that summarises the reviews that took place that day. It was agreed to review the man again in seven days.

On 19 May, the man said that he had no problems and that he got on well with his cellmate. On 20 May, the man was given an inter-prison phone call to his two brothers who were prisoners at HMP Swansea.

On 22 May, the man refused to see the doctor. He said that he felt alright, but light headed due to high sugar levels. He was persuaded to see the doctor and gave a urine sample, but then refused to see doctor again. Again he was persuaded to do so. At that time, the man said that he had no suicidal thoughts.

On 23 May, the man had no problems on association. Medical staff recorded that his blood sugar levels were high.

On 25 May, the F2052SH was case reviewed. The man once again chose not to attend the review board. The board concluded that the document should be kept open so that staff could support the man a bit longer. Staff said that he appeared low in mood and that he stayed in his bed or cell a lot of the time. Again the review was multi-disciplinary, but again the record was brief with only a basic support plan. As on 18 May, a more detailed account of the review was published in a document that summarises the reviews that took place that day. It was agreed to review the man again in 14 days. Level 3 observations were maintained.

On 26 May, the man was said to be in good spirits. On 30 May, medical staff thought that the man's diabetes was out of control. He was seen by the diabetes nurse and was to be assessed again in seven days. On 31 May, staff said that the man had no problems and that he had been fine.

On 1 June, the man was quite loud and a little threatening to an Operational Support Grade (OSG), when she was supervising the serving of the evening meal. She had refused to serve him a crumble pudding which contained sugar and was against the doctor's instructions. She was also familiar with the diabetic prisoners and the restrictions on their diet. The man was given a warning which was noted in his history sheet (F2052a).

The following evening, 2 June, the man again became vocal when another experienced OSG, refused to give him some sponge pudding. This time he threw the tray of food in the direction of the OSG, but not specifically at her. The OSG says that the incident was more disturbed and desperate than aggressive. However, the OSG placed the man on disciplinary report for throwing a tray. At 8:40pm, the man was issued with a "F1127 – Notice of Report" form which told him of the charge. Staff told my investigators that these actions were out of character for the man.

The man's cell-mate, told my investigators that the man was worried about being put on report.

3 June 2005

The night patrol OSG checked the man throughout the night, and found him and his cell mate to be very chatty. She said that both prisoners were laughing and joking, as they had been all week. She last spoke to him around 2:00am, before he went to sleep. She says that "the man seemed his usual self". At 5:40am, he was lying on

his bed and appeared to be asleep. The night patrol says that she last checked the man at 6:20am, when he still appeared to be asleep (although this is not recorded, as the 5:40am check was the official one, and this one was extra).

When an officer started her duties that morning, the first job she did was to check the prisoners on a F2052SH. There are no instructions on how to organise this. The early start officer's method was to put the documents in location order, then go to the cell furthest away from the office and look in the cell. She would then work her way back to the office. That morning there were five or six prisoners to check, and the man was the first. At about 7:20am, the early start officer found the man hanging from the window bars using a piece of torn bed sheet as a ligature.

The early start officer called for assistance and other officers who quickly responded. The officers immediately took the weight off the ligature and supported the man. One officer did not have the any cut-down equipment with him, so improvised to save time and used his lighter to burn through the ligature. The ligature was still tight around the man's neck, they broke a disposable safety razor. Whilst one officer held the sheet away from the man's neck, the other cut the sheet.

The healthcare manager was on the wing attending to another prisoner and heard the call for assistance. He arrived at the cell at the time that officers were supporting the man's body. The healthcare manager thought he could feel a pulse so the officers immediately commenced cardio-pulmonary resuscitation (CPR).

When the man was discovered, his cell-mate was asleep on the top bunk. He told my investigators that he heard nothing and had assumed that, when staff came rushing into the cell, it was going to be searched. He explained that he is a heavy sleeper and has the ability to cut noise out, in order to sleep. He said this was both in and out of prison. The cell-mate said that, if he had heard what the man was doing, he would have called for help and intervened.

The emergency services received a call at 7:30am. At 7:40am, an ambulance arrived at the prison and, minutes later, the ambulance crew took control of CPR. At 8:20am, the ambulance left the prison and took the man to hospital. At 8:30am, a doctor said that the man had sadly passed away.

Events after the man's death

The family lived quite a distance from Gloucester, so the Governor contacted HMP Cardiff and arranged for them to visit his mother and inform her of the man's death. This was done at 11:20am by the prison chaplain, and was handled with appropriate sensitivity.

The Safer Custody Manager at Gloucester was appointed as Family Liaison Officer (FLO).

Three of the eight staff involved in the discovery of the man and the attempts to resuscitate him submitted brief memoranda to the Governor. However, these contained only the bare facts, and did not present a detailed account of the circumstances leading up to and after the discovery of the man's death.

At 12:50pm, the Governor chaired a “hot debrief” for staff. It appears that all staff involved that morning attended and discussed the events. However, the OSG who placed the man on disciplinary report the previous evening was not aware of the debrief. She told us she felt her attendance would have been helpful, and that she would have benefited personally from the debriefing process.

On 13 June, the Governor, in the company of the Chaplain and the prison’s FLO, visited the man’s mother at her home address. They discussed the concerns and questions she had about the man’s death.

On 7 July, my colleagues visited the man’s mother. During this meeting a number of issues were raised which I hope are covered by this report.

One issue that remains a puzzle concerns the man’s glasses. On the telephone to his mother, he had complained that the police had retained his glasses after his arrest. He said that he was struggling to see without them. He also complained to his cellmate that he needed his glasses to see properly. However, there is no evidence that the man mentioned any difficulty to staff. Nor does the question of his glasses does not feature in any of the assessments made. The healthcare manager outlined to my investigators the comprehensive steps that the prison would take should a prisoner need glasses.

Clinical review

The Assistant Director for Clinical Governance at West Gloucester Primary Care Trust carried out the review. She concludes that the man was cared for well in the prison. It is evident that the man’s diabetes was troublesome, but better monitored that it would have been in the community.

Findings and Conclusions

There is no doubt that the man was troubled by the fact that he was held at Gloucester prison, and not in Wales. He was accustomed to being in prison, but not at that distance from his family. He particularly missed his mother, who was not able to travel the distance to Gloucester.

The Prison Service accepts that holding prisoners in prisons where it is difficult for families to visit is undesirable. However, given the overcrowded nature of the prison estate, it is increasingly hard for the Prison Service to avoid this. In this case, the Governor considered the man's request for a transfer and decided that it was not practical until the time when he was due to be produced in court. This is not a desirable situation, but in the circumstances it was not an unreasonable decision.

On 10 May, the prison was alerted by relatives that the man might be suicidal. The prison acted quickly and appropriately and, following an initial assessment, opened a F2052SH document.

F2052SH

The F2052SH was opened correctly and the man was assessed by health professionals. The decision to manage the man on the wing was appropriately made.

When a F2052SH is opened, and the prisoner is not referred to the HCC, a doctor must assess the prisoner within 24 hours. This did not happen and was highlighted in a management check on 15 May. A F2052SH must be case reviewed by a multi-disciplinary team within 72 hours. This did not happen either, as again was highlighted in the management check. In neither case was any remedial action taken. The system of management checks works well. But in this case it was of limited benefit as no remedial action followed.

Additionally, the check commented on the fact that a "Discharge Report" was not completed. However, this was not required, as the man had not been admitted to healthcare. This indicates that the manager checking the F2052SH was not fully aware of all the elements of the system.

The F2052SH was not closed at the multi-disciplinary case reviews held on 18 and 25 May. On the evidence available at that time, these decisions were appropriate. Both case reviews were recorded well in a document that outlines all the reviews that took place that day, but unfortunately the account in the F2052SH itself was brief. It should have been more detailed to make sure that anybody reading it was aware of all the potential issues.

I am satisfied that, overall, the observation levels were appropriately considered and were followed. However, the observation level prescribed on the initial HCC assessment was "3:1 obs", when the local policy outlines three levels of observation – one, two and three. Although the practical outcome

was the same, the use of different terms by staff could lead to confusion and should be avoided.

Entries in the supervision and support record indicate a good balance between observations and interactions with the man.

Placing the man on Disciplinary Report

On learning of the man's diabetes, the doctor wrote to the catering staff instructing that the man be given a diet appropriate to his condition. This was provided and was understood clearly by the staff who supervised the serving of meals. On 1 and 2 June, the man made a point of attempting to gain puddings, which he was not allowed to have. Both times he became frustrated. On the first occasion, he was rude and a little threatening. This was dealt with informally and the man was given a warning. On 2 June, he threw his meal tray in the direction of a member of staff and was placed upon disciplinary report. I conclude this was appropriately handled on both occasions.

The man's cell-mate, said that the man was worried about being put on report. However, this was not a serious offence and would not have resulted in a harsh punishment. The night-patrol officer said that, when she checked on him during the evening and night, the man was very much his normal self. It seems unlikely that the question of being put on a disciplinary charge weighed unduly heavily on the man's mind.

Emergency Medical Assistance

The man was found hanging in his cell shortly after 7:20am. The ligature was made from a prison bed sheet, the most common means of suspension in prison, and was easily cut. Although using a lighter and broken safety razor was unconventional, it was effective and saved time. It would have taken between one and two minutes for staff to leave the cell and collect the special cut-down scissors from the office. It would be better and safer for staff working with prisoners to be issued with a pair of cut-down scissors, or a fish-knife, which is specifically designed for the purpose of cutting ligatures.

It is surprising, but understandable that the prisoner who shared a cell with the man, remained asleep until woken by staff entering the cell. This was not unusual for him, especially as he had been awake until after 2:00am and he was accustomed to blocking out general prison noise.

The response was immediate once the alarm was raised. Medical professionals were administering emergency aid within minutes of the man having been found. It is to the credit of all concerned that every effort was made to revive the man. The prompt arrival at the cell of the Ambulance Service is also impressive.

After the man was discovered

Procedures were followed in line with contingency plans. The various offices and individuals were informed of events as required.

The prison FLO played a hugely important role in keeping the man's family informed of events and helping them come to terms with what had happened.

The OSG who placed him on report was not aware of the hot debrief held by the Governor. Her attendance would have been helpful. There is no doubt that she would have benefited from the debrief process, given that she had placed the man on a disciplinary report the previous evening.

PSO 2710 (Follow up to deaths in custody) requires that the "hot debrief" involves staff only involved in the incident itself. The prison should make sure that post incident support/care arrangements are extended to all staff.

The memoranda submitted to the Governor by staff involved did not present a detailed account of events. It would have been helpful to have had a comprehensive account from all staff involved, particularly as the account would still have been fresh in people's minds. My investigators found themselves interviewing more staff than would have been necessary if comprehensive statements had been made immediately following the man's death.

Although it is covered in PSO 1400 (Contingency Planning), PSO 2710 does not include instructions on the completion of statements following a death in custody. Experience shows that a number of establishments have locally devised forms which staff complete following an incident. I think that the PSO should make it a specific requirement for Governors to collate comprehensive statements from staff following a death in custody. A useful example is the form that the Prison Service uses following an incident requiring the use of force (Use of Force Form – OF005 2326).

The breaking of the sad news of the man's death to his family was handled well. Because of the distance involved, it was appropriate to ask another prison to contact the man's mother. The Governor's visit to the family on 13 June was sensitive and well judged.

Medical Care

The clinical review concludes that the man's medical needs were managed appropriately by the prison.

Whilst the man complained to his mother that he had no glasses, there is no evidence that he asked the staff at the prison for a replacement pair. There are adequate procedures in place for prisoners at Gloucester to have access to an optician and receive glasses.

Suicide Awareness

Gloucester prison's local "Suicide Prevention Strategy" is a comprehensive policy document which is consistent with national policy.

Whilst he was at Gloucester prison, the man was identified as being vulnerable, properly assessed and supported. However, on 3 June it appears he took his own life. There had been an incident over food the day before, which was uncharacteristic but had been relatively minor. Staff and prisoners, including his cell-mate, had no suspicions that the man might wake early on 3 June and take his own life.

Detoxification

The man died nearly a month after successfully completing his detoxification from heroin using diazepam and dihydrocodeine. However, it is clear that prisoners who are undergoing or have recently undergone detoxification are at special risk of suicide or self-harm. The sad circumstances of the man's death provide an opportunity for Gloucester to review its approach to detoxification both clinically and in terms of the other support available to prisoners.

Recommendations

1. I recommend that the Director General of the Prison Service considers revising PSO 2710. It should include a specific requirement for Governors to collate comprehensive statements from staff following a death in custody. A useful example is the form that the Prison Service uses following an incident requiring the use of force (Use of Force Form – OF005 2326).

2. I recommend that the Governor reminds staff that, when setting observation levels, they use terminology consistent with the local policy.

3. I recommend that the Governor reminds staff that case conferences carried out 72 hours after the opening of an F2052SH reviews are conducted by three members of staff, as local procedures require.

4. I recommend that the Governor reminds medical staff that a doctor must review all prisoners on an open F2052SH within 24 hours of the document being opened.

5. I recommend that the Governor considers whether “Fish-knives” or similar equipment should be made available to staff who work with prisoners.

6. I recommend that the Governor reminds senior colleagues of the need to extend post incident support/care arrangements to all staff. (This is to ensure that staff involved with prisoners prior to incidents, but not directly involved on the day, are afforded appropriate care.)

7. I recommend that the Governor and Area Manager review Gloucester’s approach to detoxification both clinically and in terms of the other support available to prisoners.