

**Investigation into the circumstances surrounding the
death of a man in March 2012 at HMP Swaleside**

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

November 2012

This is the report of an investigation into the circumstances surrounding the death of a man. He was found in his single cell at HMP Swaleside on a morning in March 2012, suspended from a light fitting. He was just 22 years of age at the time of his death. I extend my condolences to his family and friends.

The investigation into the man's death was carried out by an investigator. A clinical review was conducted by a clinical reviewer, on behalf of the local Primary Care Trust (PCT). Staff at HMP Swaleside co-operated fully with this investigation.

The man had no history of substance misuse, mental illness or harming himself. He was respectful to staff, was employed as a wing painter and associated well with other prisoners. As the result of an altercation with a friend, and for his own safety, he was moved to another wing two days before his death. We conclude that the move was appropriate and there is no evidence to suggest it contributed to his subsequent actions or that staff could reasonably have foreseen or prevented him from taking the action that he did.

Nevertheless, we do identify a number of areas for improvement at Swaleside, particularly regarding weaknesses in roll check and unlock procedures, which meant that the man was only discovered a lengthy period of time after his death and, even then, by another prisoner rather than a member a staff. I am pleased that the governor took immediate action as a result of our early feedback on these matters. The report also makes recommendations to address concerns regarding poor recording practice (at both Elmley and Swaleside) and the need for better emergency arrangements.

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

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SUMMARY

1. The man was remanded into custody at HMP Elmley on 20 October. During the reception process, he expressed no health concerns and denied any thoughts of harming himself. On 19 November, he complained to the prison's nurse that he was feeling depressed at being in prison. This was the only occasion that he expressed such feelings.
2. On 21 January, 2011 the man was sentenced to five years imprisonment. Over the following months he appears to have settled in well at Elmley.
3. However, on 25 May, he spent a number of weeks in the prison's segregation unit, having staged a protest by climbing onto the roof of the prison's gym. During his time in the segregation unit he was seen daily by healthcare staff and no concerns regarding his health were expressed.
4. The man was transferred to HMP Swaleside on 15 September. He was seen by a reception nurse, who noted that he had no concerns about his physical health and he expressed no thoughts of harming himself. Up until his death he had no further contact with healthcare staff at the prison.
5. He settled well at Swaleside. He gained a trusted position as a wing painter and mixed well with other prisoners. During his time in prison he had frequent contact with his family through visits and by telephone. No concerns were expressed either by himself or by staff during this time.
6. On 18 March, he was involved in an altercation with another prisoner, with whom he had been friends. Fearful for his safety, and for security reasons, he moved wing. It was expected that he would return to his old wing within a couple of weeks. Several days later he was found in his cell hanging from the light fitting by another prisoner during unlock for breakfast. Three different members of staff carried out roll checks and unlocked his cell, but none of them noticed he was hanging.
7. The prisoner who found the man raised the alarm and officers responded promptly. After a slight delay, healthcare staff arrived at the scene. Staff did not attempt resuscitation because it was clear that he had been dead for some time.
8. The report into the man's death makes several recommendations, related to the roll check and unlock of prisoners and the importance of checking prisoners correctly during these times. We also make recommendations regarding the need to improve the personal officer scheme and record-keeping. Finally, concerns are expressed about the delay in the attendance of healthcare staff after the alarm was raised and a further delay before an ambulance was called.

THE INVESTIGATION PROCESS

9. The investigator was appointed to conduct the investigation into the circumstances surrounding the man's death. He opened the investigation on 27 March, when he visited HMP Swaleside. He met the Deputy Governor and other members of prison staff. He met a representative from the Prison Officers' Association (POA). He also asked to speak with a member of the Independent Monitoring Board (IMB), but none were available. (IMB members are independent and unpaid volunteers who monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained. The POA is a trade union for prison officers.)
10. Notices informing prison staff and prisoners of the investigation were issued, inviting staff and prisoners to contact the investigator with any relevant information. A number of prisoners came forward and the investigator spoke to them and prison staff during several further visits to the prison. During the investigation the investigator provided verbal feedback to staff and governors, which was confirmed in writing to the then Governor of Swaleside.
11. The investigator was shown the wing and cell where the man spent the last days of his life, as well as visiting other areas of the prison. The investigator reviewed documentation and listened to a number of telephone calls that the man made in the days before his death.
12. A clinical reviewer reviewed the clinical care that the man received while he was in prison on behalf of the local PCT. During the investigation the investigator liaised with a Detective Sergeant from Kent Police. He has also been in contact with the Coroner's Office and a copy of this report will be sent to the Coroner to assist with her enquiries.
13. One of our family liaison officers contacted the man's family to tell them about the investigation and to offer them the opportunity to ask questions about his time in prison. On 31 May 2012, the liaison officer and investigator met the man's mother and father. His family's concerns included:
 - How their son was able to use the light fitting in the cell as a ligature point.
 - Why their son had been found by another prisoner and whether staff on duty conducted the roll checks and unlock appropriately.
 - What time their son had died.
 - The circumstances of the fight between their son and another prisoner on the wing and why he, and not the other prisoner, was moved.
 - Whether their son was bullied.
 - Why the Governor had made an inappropriate comment during the memorial service.

- Whether there had been a press release before the family had been told of his death.
14. It is hoped that the report answers these and any other questions that the family may have.
 15. The man's family also asked whether or not their son was located in a safer cell. Safer cells are designed to make the act of suicide or self-harm as difficult as possible. This is achieved chiefly by reducing ligature points. They are specifically designed to contain fewer ligature points than ordinary cells. Many of them often also contain furniture which is designed to minimise the potential for self harm rather than removing it altogether. During his time at Swaleside, he was located in standard cells. He was never considered at risk of harming himself in custody, so he was never located in a safer cell.
 16. The family received a copy of the draft report as part of the consultation period. Written representations were provided on behalf of the family in response to the findings of the investigation. A number of areas of concern were raised including the actions taken by the prison following an altercation. The family welcomed the recommendations made in the report however felt that the investigation did not go far enough. Although the comments have led to no changes in the investigation report, the investigator has addressed the issues raised in separate correspondence to them and legal representative.

HMP SWALESIDE

17. 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 conditions are not necessary, but for whom escape needs to be made very difficult.) Although the cluster of prisons shares a number of administrative functions, each of the establishments is run by a Governor who reports to the Area Deputy Director of Custody.

Her Majesty's Inspectorate of Prisons (HMIP) Report September 2011

18. HMIP carried out an unannounced inspection of Swaleside in July 2011 that concluded:

“Swaleside seemed a fundamentally safe prison, and work to address safer custody issues was well developed.”

and reported that:

“Prisoners told us that relationships with staff continue to be respectful and friendly. The quality of personal officer work remained good and there was an active plan to develop this further.”

Previous self inflicted deaths at HMP Swaleside

19. The man's death is the sixth apparently self-inflicted death at Swaleside since the Ombudsman started investigating deaths at the prison in April 2004.

KEY EVENTS

The man's time at Elmley

20. The man was arrested on 19 October 2010 for burglary and threats of violence. The following day, he appeared at Magistrates' Court and was remanded into custody at HMP Elmley. This was not his first time in prison.
21. During the reception process, staff recorded the man's personal details on page one of his core record F2050, (the reception record completed for all new prisoners). He provided the details of his mother as his next of kin.
22. During the man's first reception health screen, the nurse noted that he expressed no health concerns. (All prisoners are given a first night reception health screen when entering prison. The aim of the screen is to identify a prisoner's health needs, including their past medical history.) He told the nurse that he did not take any drugs, prescribed or otherwise. The nurse recorded that he made good eye contact that his speech was normal and he denied any plans to harm himself. The following day a further health assessment took place and no problems were identified.
23. On 15 November, the man pleaded guilty to two counts of robbery, committed in 2008 and October 2010. On 19 November, he told a nurse that he thought he might be depressed due to being in prison, losing his girlfriend and feeling that he was losing touch with his family. Although he had been in prison before, he said he had "... never felt this way". The nurse referred him to the primary mental health team. There is no evidence that he was ever seen by the mental health team. The clinical reviewer notes that this is the only reference in the man's medical notes of him ever being depressed while in prison.
24. During a pre-sentence report meeting on 17 December, the man told his probation officer that he had never suffered from any mental health problems, harmed himself or had had any thoughts of suicide.
25. He received a five year sentence at Crown Court on 21 January 2011. When he got back from court, he was assessed by a reception nurse, who recorded in his medical record that he had been anticipating his sentence and described him as "stoic ... clear, concise and frank throughout". The nurse noted that he expressed no thoughts of suicide or self harm and explained how to access support services in the prison if he found difficulty coping with his change in circumstance.
26. Only three entries were made in the man's case history over the following few months; two for negative behaviour, refusing to return to his cell and kicking his cell door. There were no entries at all in his case history from 31 March to 22 May, nearly two months.
27. On 25 May, he climbed on to the gym roof with another prisoner for several hours as a protest about the regime. When he ended his protest, he was taken to the segregation unit where he was seen by a nurse who reported that he had

no injuries. He was assessed daily in the segregation unit by healthcare staff and no concerns were raised.

28. On 13 June, he was transferred back to the wing, but soon smeared faeces over the observation panel of his door. He was subsequently returned to the segregation unit and adjudicated for damaging prison property and for racist behaviour. (An adjudication is a disciplinary hearing, which is held to ascertain whether or not an offence has taken place or prison rules breached. If found guilty the adjudicator may impose a penalty.)
29. The man was assessed daily by healthcare staff. On 20 June, he told a nurse that he wanted to be moved out of Elmley, or he would “do something stupid”. His mental state was assessed as stable. On 22 June, he flooded his cell and smashed the observation panel. On 2 July, he requested to the mental health team and on 6 July, he was seen by one of their nurses. She noted:

“... no overt psychotic symptoms were observed or reported, no mental health problems reported. Currently denies any self harm / suicidal ideations. States he is quite happy to locate to any Houseblock except for Houseblock 6.”

By 7 July, his behaviour had improved and he was relocated to Houseblock 2.

30. According to one of the rare entries in the man’s case history on 10 August, he appeared in:

“... good spirits and said his cell mate was a good laugh he also stated that he was looking forward to seeing his family in few days on a visit, no issues or concerns at present.”

On 13 August, it was noted that he was a wing cleaner and on 23 August, he told staff that he wanted to improve his behaviour in order that he could received further privileges while in prison.

The man’s time at HMP Swaleside

31. On 15 September, the man was transferred to HMP Swaleside. A nurse carried out a health screen and recorded no concerns about his physical health or the likelihood of harming himself. After this assessment, he had no further contact with healthcare staff at the prison.
32. The man spent the first six weeks of his time at Swaleside on the induction unit. On 20 September, he received a gym induction and two days later changed his religion from none to Roman Catholic. On 25 October, he was moved to F wing. He continued to live on F wing, without incident for several months.
33. An officer was allocated as the man’s personal officer on 4 January 2012. (Each prisoner is allocated a personal officer, who is the first point of contact for them whilst in prison.) The officer noted that he caused no problems on the wing, was always willing to help, worked as a wing painter and mixed well with other

prisoners. He told the investigator that there was no evidence that he was ever bullied or was involved in drugs on the wing. He said that to his knowledge he never said he would harm himself.

34. On 10 January, an officer noted in the man's case history that he carried out his job as a wing painter with great enthusiasm, that he worked efficiently and was doing a good job. On 31 January, the personal officer noted that he had shown a great deal of improvement whilst on the wing and carried out his work to standard and without prompting.
35. During his time in prison the man spoke to his mother and other family members regularly on the telephone. In a telephone conversation with his mother on 1 March he gave no indication that he was experiencing any problems in the prison.
36. He spoke to his mother for the last time on the afternoon of 7 March. They spoke of day to day matters, including future visits by family members and he raised no concerns about his situation. On 10 March, he received what was to be the last visit from his mother, who later told the police that he appeared in good spirits and not depressed during the call.
37. An officer who worked on F wing said that the man was close to a small number of prisoners, Prisoner A in particular. The officer told the investigator that the group often gathered in his cell because it was at the end of the wing. The officer said that as Prisoner A was a difficult character his association with the man was seen as positive. A Senior Officer (SO) said that there had never been a problem between the two prisoners and that the man had never complained about him previously.
38. The officer recalled that a few days before his transfer to A wing on 18 March, the man and Prisoner A fell out. He said that the man assured him that nothing had happened or was going to happen between the two prisoners. He said the following day Prisoner A and the man appeared to have made up their differences and were interacting with one another as normal. He told the investigator that there had never been any problems before between the man and Prisoner A.
39. On the morning of 18 March, the man attended chapel for the first time at Swaleside. One chaplain explained that the service was led by a chaplain from the man's home area. He said that he had no concerns about him that morning. Prisoner B, a prisoner at Swaleside, told police that he briefly spoke with the man at church, at about 9.30am, that morning. The prisoner said he looked depressed but said he was okay. The man returned to his wing before lunch.
40. Shortly after lunch on 18 March, a SO was alerted to an altercation between Prisoner A and the man, along with other staff. As they reached the pair, other prisoners dispersed and both men were returned to their cells. The SO told the investigator that, as neither of the prisoners had sustained any physical injuries and there was no evidence that a fight had taken place, so healthcare staff were not called to attend. Neither the man nor Prisoner A was subsequently placed on

report. (When a prisoner has broken a rule, staff put him on report. The prisoner must be told within 48 hours what offence he is accused of having committed and an adjudication is held.)

41. Once the wing had been locked up, the SO went to see the man in his cell he told the investigator:

“I went and saw him, and he was sat on his bed. And I said ‘is everything okay, what’s going on’ and he had the look on me, he looked at me and said ‘no, everything’s fine’ and you could clearly tell it wasn’t. But he didn’t want to say, he just didn’t want to say, but you knew there was. So I said ‘look, would it help if you moved wings’ and he looked at me and said ‘I can’t’, and I thought that was a bit odd. It was like he was trying to save face and he wanted to front the problem. So I said ‘would it help if I moved you wings, so you had no say in the matter’ and he just looked at me and said ‘I can’t’, so I thought I’m not happy with this.”

42. The SO told the investigator that he considered Prisoner A’s previous history of fighting and what he described as his explosive temper. The SO decided to move the man to another wing for his own safety. He said that he had no idea what the two prisoners had argued about.
43. The move to A wing was approved by the duty governor. The SO said that when he told the man that he would be moving wings, he did not argue. Although he agreed to move, the SO thought he did not want to, suggesting that he did not want to “lose any face”.
44. The SO made the following entry in the man’s case history:

“The man has had a dispute with Prisoner A, the cause of this is unclear. For this reason only he is being moved to Alpha wing as a precaution. He has worked well on Foxtrot wing and I’m sure he will continue to do so on Alpha.”

The SO submitted a security report. He noted that the man and Prisoner A had had a disagreement, but that it was unclear what it was about as both were good friends and suggested that the “... problem will not resolve itself.” In the wing’s observation book the SO wrote:

“There appears to be an on going argument between these two offenders. It is unclear what it is about as they were both good friends.”

45. The investigator was unable to find any evidence to suggest that the man had been bullied during his time in prison. The investigator sought further information from the SO asking if the man had ever been involved in drugs or had been the subject of bullying. The SO said that to his knowledge, he had not. When asked if he would have approached staff if he had been bullied the SO said:

“That’s difficult to say because on the day that I moved him off the wing I saw a side to him that was a very proud sort of person. And I think if he had been bullied he might have tried to deal with it himself, whether that’s not telling anyone and not doing anything about it and just taking it on the chin. Or whether he’d come to a member of staff with it, I don’t know, it’s difficult to say.”

The man’s move to A-wing

46. The man was relocated to A wing at about 1.30pm on 18 March and he was given a single cell on the ground floor of the wing. The SO said that he packed all of his possessions to take to A wing. He said that either at this time, or during any previous contact with him, he gave no indication that he was at risk of harming himself or expressed any suicidal thoughts.

47. He was taken to A wing by an officer. The officer said that he had no physical injuries and told the officer that “nothing had happened”. He told the investigator that he asked him:

“... ‘what’s going on, what’s gone on, you two were close friends, what has happened’. And he said ‘that’s what I don’t understand, I don’t know, nothing’s happened, I haven’t done anything’.... there were obviously bad feelings from Prisoner A’s point of view towards him, but he couldn’t explain what he had done to upset him.”

The officer said that when he was shown his new cell he asked staff for a mop and bucket in order that he could clean it. The officer said that he was in good spirits.

48. Later that afternoon, the man asked if he could spend some time with another prisoner he knew from Elmley and who was also on A wing. Another officer told the investigator that the two prisoners drank coffee together and that he seemed fine.

49. The prisoner in the cell next to the man’s on A wing told the investigator that he was quieter on A wing but thought that this was because he had moved to a new wing. He understood he had been involved in a fight on his previous wing and was expecting trouble from another prisoner.

50. A prisoner who had shared a cell with the man for about three months at Elmley told the investigator that he appeared to be okay the evening before his death. He said the man was relaxed at being in prison and was not involved in drugs. Before being locked up that night, he said that they would see each other in the morning. The investigator asked him about any unusual noise on the wing that evening. He said that he heard no loud music and, with regard to noise, it was a “regular night”.

51. A prisoner from F wing told the investigator that he believed the man had been bullied by Prisoner A. He said that this prisoner had made threats to him directly and threatened his family. When asked, the prisoner said that he did not believe

the man took drugs and was not in debt. He said that he would have helped him had he been in debt. He did not tell staff about his concerns.

52. A prisoner told the investigator that the man was neither dangerous nor violent and would not be able to stand up for himself. Contrary to the accounts of other prisoners, he said that the man liked to take drugs or hooch and that he would use both. He said the man had obtained tramadol the day before he died. The prisoner said that when the man moved to the wing he was laughing as always but believed deep down that he was paranoid and scared. He later told staff that the man had used drugs, which he had obtained from another prisoner and that the night before his death he was "off his nut".
53. Prisoner B told police that he saw the man at about 7.00pm on the evening of 19 March. He told police that he was very upset and stressed and said that he did not know why Prisoner A had punched him and that he had also done so previously. (There is no evidence to suggest that this prisoner punched him on 18 March, or that he had done so previously.)
54. An Operational Support Grade (OSG) told the investigator that he arrived on the wing at about 8.15pm and completed a roll check by counting all of the prisoners on the wing. He said that during a roll check staff were expected to:

"... check that they're [prisoners] there and that they're alive and there is either movement or breathing or some sort of response. If they're asleep we generally don't wake them up but we usually check if they're moving or there's movement."

Adding that if he had any concerns he, "... would try and get a response from them", but that there were no concerns that evening.

55. At 9.25pm the man wrote a letter addressed to his mother and others who cared for him. He apologised for the pain "... I've caused now and in the past" and that he had, "... done this because there is only one other path for me to follow and that's a life of sadness." In the letter he expressed his love for his family.
56. The OSG explained that one of his responsibilities during the night of 19/20 March was to carry out "pegging" which meant patrolling the wing. (Pegging is an electronic security system, which records when a landing has been visited by an officer.) He said:

"We don't physically check everybody's cells, we just go around listening for anything suspicious and smelling for suspicious smells and what have you and just basically patrol the wing and that's what we do every hour or so."

He recalled asking a prisoner in the first cell on spur 1, the spur on which the man was also located, to turn his music down. He told the investigator that the wing was "fairly quiet" that night.

57. The OSG remembered doing the roll check, the following morning 20 March, at around 5.50am, starting on the top landing, moving to the bottom landing, before finishing on the middle landing where his office was. The OSG told the investigator that it took about ten minutes to complete the roll check and that he phoned through the roll at about 6.00am to 6.05am. He said as far as he could recall the man was asleep in his bed at this time, as most prisoners would be at that time of the morning. He said:

“I looked in all the cells and as far as I can remember I thought he was asleep. I thought I saw him moving, I don’t know. I’m not sure if I saw him moving or not but I must have done otherwise I would have been suspicious, so I moved on.”

58. Officer A told the investigator that he arrived at the prison at about 7.00am on 19 March and arrived on A wing at about 7.05am, when he immediately started his roll check. When asked if he had checked all three landings, the officer told the investigator:

“I believe so, yes. I’m sure I did all of them, absolutely every one of them. Whether he was up there [the OSG] whilst I was on the ones and then he come down and I’ve done the threes again, I don’t know, but I remember doing every single cell.”

59. The investigator asked the officer how long a roll check took to complete on A wing. He said that it was variable but it would normally take between 15 and 20 minutes. When he described the count on 19 March, he said, “... I’m not going to lie, it was a bit of a quick count.” He said, “In the case of the man, when I looked in his cell I saw a shadow, like a silhouette, and the position of it of where he was in front of the sink.” He said that at the time he thought he was drying his hair. Once he had completed his roll check, he returned to the wing office, signed that the roll had been completed, and phoned the roll thorough to the Temporary Senior Officer (TSO) in operations.

60. The investigator walked the route of a roll check and estimated that it would take approximately five to six minutes to check each landing. The investigator concluded that it would have taken at least 15 minutes to complete a count of all three landings on the wing.

61. The OSG told the investigator that he assisted the officer with the roll check that morning, by counting the threes landing while the officer counted the ones and twos. The OSG said that he would not normally help with the morning roll check, unless the officer arrived later than expected. He said that when the officer arrived on the wing he was apologising for being late, although he was not. The OSG said that he had on occasions before assisted other officers with their roll checks, “... giving them a hand really.” (the officer’s official start time was 7.30am and the OSG’s finish time was 8.45am. However, it is common practice at Swaleside for early start officers to relieve the night OSGs early.)

62. The TSO was the orderly officer that morning and at about 7.10am, he received a call from the officer confirming the A wing roll. He had seen the officer arriving

for duty and was concerned that it seemed a bit quick to have conducted a full roll check of A wing and rang the wing back. The officer confirmed that he had completed a full count of the wing.

63. The TSO said he asked the OSG about the roll check on his way off duty. He said that he had assisted the officer with the count.
64. At about 8.10am, Officer B unlocked the wing and told the investigator that she never opened a cell door without looking through the observation panel first. However, because his cell was in darkness she assumed that he was asleep and may have been having a lie-in.
65. Prisoner C said that he went into the man's cell most mornings and had planned to go to his cell for a coffee. He said that he "bounded" into the cell and almost walked straight into him. He was hanging by a strip of bed sheet from the light fitting.
66. He said that he shouted out, "... get a fucking screw here now...you let me find him, why did you fucking let me find him". He said he was very upset and kicked over the fridge, which was on the landing outside, in anger and frustration. He said that staff arrived immediately and raised the alarm.
67. At 8.18am, a SO, who was working on the landing above, pressed the general alarm. (On the calling of an alarm the emergency medical response team at Swaleside responds immediately, taking all emergency equipment.) At the same time, the officer became aware of an "animated and distressed prisoner", Prisoner C, on the first spur. The officer told the investigator:

"I didn't know what was going on, all I had was a gentleman behaving very distressed and he was also kicking the fridge. He then tipped the fridge over and it was only when he said "you didn't check him, you didn't check him", that I realised there was something in the cell that was relevant and again you lose things in the moment but suddenly the prisoner wasn't in the way. I think he'd moved to the side. I don't know where he went but he suddenly wasn't in the way anymore and I felt able to go past him. As I've got to the door because it's right at the far end of the spur, I've opened the door and there is a suspended body from the light fitting."

68. Another officer followed Officer B into the cell. He supported the man's body while Officer B cut the bed sheet. He had worked the bed sheet into an extremely small gap between the light fitting and the ceiling in order to secure the ligature. Both officers lowered him onto the bed. Officer B said that he was very cold and that he was cyanosed (his skin was turning blue). Although not clinically trained, both the officers thought he had been dead for some time. The officers decided not to start cardio pulmonary resuscitation (CPR). Another officer and two SOs arrived at the cell shortly after in response to the general alarm.

69. In her statement to police, the officer said that on her arrival at the cell she was about to make an emergency call for a code blue, but that another officer radioed the code blue first. (A code blue is an emergency call sign used to alert staff to a medical emergency involving breathing difficulties.)
70. A nurse told the investigator that he and his colleague were in the healthcare centre when the general alarm and subsequently the code blue was raised. His colleague took the emergency response bag, which contained oxygen, a defibrillator and other equipment and went to A wing.
71. The two nurses arrived on A wing at 8.20am, two minutes after the alarm. The nurse told the investigator that he and his colleague were kept waiting in the office for a further two minutes, having been told by an officer that it was a false alarm, but he could not remember who had said that. A SO then told the nurses that someone had been found hanging on the lower landing. The nurse and his colleague went to the cell. He described the man's condition:
- “... [his] body was very, very cold ... his legs were stiff, there was no breathing, pupils were fixed and dilated. It appeared to me anyway that he'd been dead for some time.”
72. He asked if an ambulance had been called and, although it is not clear who made the call for an ambulance to attend, the control room log records that the Ambulance Service was called at 8.22am. The two nurses decided that it would not be appropriate to attempt resuscitation. The paramedics arrived at 8.36pm and no further treatment was given. The ambulance service log notes that on the arrival of paramedics “obvious signs of death, cold to touch, rigor mortis, no palpable pulses nor resp effort, silent chest.” Paramedics pronounced him dead at 8.40am.

Prisoner support

73. Prisoners were collecting their breakfast when the man was discovered, so knew of his death. Nevertheless, staff formally told prisoners that he had died. Prisoners were offered support by the chaplaincy, Listeners and Samaritans. (A Samaritans supported Listener scheme in place for prisoners who are in distress or crisis and need to talk in confidence.) All prisoners subject to suicide and self-harm monitoring were reviewed.
74. After the man's death, a SO let Prisoner C sit with another friend on the wing for most of the remainder of the day. The prisoner said he was also offered a Listener, with whom he spoke and received counselling.

Staff support

75. All staff involved in the discovery of the man were invited to a hot debrief. (A hot debrief is a meeting to give staff the opportunity to share their feelings following involvement in a traumatic incident.) Staff told the investigator that they found it helpful to go through what had happened and that the support from the prison's care and welfare team had been good. However, two members of staff told the

investigator that they had not been invited to the hot debrief, although support was later offered.

Family liaison

76. A SO from Elmley was appointed the family liaison officer (FLO), in the absence of Swaleside's FLO. The SO, a chaplain and the Deputy Governor visited the man's mother at her home, but could obtain a response because she was at work. Contact was eventually made with a cousin who then contacted her to break the news that afternoon. She was met at her home by the SO and his colleagues, who were able to provide some additional information with regard to her son's death.
77. On 26 March, the man's mother and other family members attended a memorial service held in the chapel at Swaleside. The service was attended by a number of prisoners who knew him and who also made a small collection for a floral tribute. Swaleside made a contribution towards his funeral expenses.
78. The family said that a governor who they met at their son's memorial service at the prison had made an inappropriate comment. Despite making enquiries the investigator has been unable to substantiate these claims.

Post-mortem report and toxicology

79. Kent police attended the prison the day that the man died and confirmed that there were no suspicious circumstances.
80. Toxicology results taken after his death shows that no prescription or other drugs were detected in his body.
81. His family were concerned about the allegation that he had used tramadol the day before he died. The clinical reviewer contacted the pathologist who confirmed that had he taken tramadol it would have been present in his blood at the time of his death, and according to the result of the toxicology report it was not. Therefore, he did not take tramadol the night before his death.

ISSUES

The man's move to A wing

82. During his time on F wing the man was regarded highly by staff and associated well with other prisoners, including Prisoner A. Staff described them as friends. Several days before 18 March, the two men appeared to fall out, and, on 18 March, they were involved in a further altercation.
83. Staff moved the man to another wing for his safety and the security of the wing. The SO said that he did not feel it was safe to leave him on the wing with Prisoner A. He said that he was concerned for the man because this prisoner had previously attacked other prisoners with whom he had argued. The SO said that because of Prisoner A's need for routine, it was decided to keep him on F wing. Despite initial reluctance, when told that he would be moving to A wing, the man cooperated fully.
84. Without the benefit of hindsight there was no reason or evidence to suggest that moving the man would have had any impact upon his welfare. He had never been identified as at risk of self-harm or suicide. We believe that the action of staff was appropriate, given the information available to them at the time.
85. The altercation between the prisoner and the man was subject to a violence reduction investigation. However, due to the subsequent death of the man, and the transfer of the prisoner to another prison, these investigations were never completed.

Morning roll check

86. On the morning of the incident, the OSG said that he conducted his morning roll check at 5.50am and observed nothing suspicious when he checked the man. The OSG said that it took about ten minutes to conduct a roll check on the wing. At about 7.05am, Officer A started his roll check and phoned the numbers through to the TSO about five minutes later. (During the investigation it became clear that the officer had in fact been assisted with his roll check by the OSG, but it was the officer who checked the landing on which the man's cell was located.)
87. The officer told the investigator that to carry out a roll check he would look through every observation panel. He said that when he checked the cell he saw what he believed to be the man standing near the cell's sink and that he appeared to be drying his hair. Given the descriptions of the man by staff when he was found, it is most likely that what the officer had observed was in fact him hanging from the cell's light fitting.
88. As previously mentioned the investigator walked the route of a roll check, and concluded that it would take a minimum of 15 minutes. It does not seem possible that the officer carried out the roll check in the time given, even with the assistance of the OSG. Indeed the speed of the count was questioned by the TSO.

89. The officer admitted to the investigator that "... it was a bit of a quick count." The OSG said that when the officer arrived on the wing that morning he was apologising for being late, when in fact he was not. (His official start time was 7.30am and the OSG's finish time was 8.45am. However, it is common practice at the prison for early start officers to relieve the night OSGs earlier than officially required to do.) It is accepted practice at Swaleside for night staff to leave earlier than their official shift ends. It is concerning that the officer thought he was late that morning, even though he was not. As a result, the roll checks were compromised during the handover between night and day staff.
90. The time of the man's death is not known, although he had probably been dead for some time. It is unlikely that he would have been saved if he had been discovered at the time of the first count, but that might not be the case in future.
91. Unfortunately, this office has had to comment previously on the correct procedures to be taken by other prisons when counting rolls and the handover from one shift to another. As in those investigations we have commented that it is for the governor to satisfy himself that the safety and care of prisoners and the security of the wing is not compromised as a consequence of handover practices between shifts. We therefore make the following recommendation:

The Governor should ensure that staff working practices are not allowed to compromise the care, safety and security of prisoners and that staff carry out roll checks in line with requirements.

92. As a result of the investigator's feedback, the Head of Residence at Swaleside carried out an internal investigation into the roll check completed on A wing on the morning of 20 March. Following that investigation, a Local Notice to Staff was issued to remind staff of the procedures to be followed when completing a wing roll check. We understand that the officer is subject to an internal disciplinary investigation.

Morning unlock – checking of cells

93. At 8.10am Officer B unlocked the man's cell. She told the investigator that she never opened a cell door without looking through the observation panel first, as she did when she opened this cell. However, she explained that, because the cell was in darkness, she made the assumption that he was asleep.
94. Guidance set out in the Prison Officer Entry Training manual states that:
- "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response, you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead."

On this occasion the officer did not seek a positive response from the man when unlocking his cell. Unfortunately he was found by another prisoner, who raised

the alarm. We note that a similar situation occurred during the unlock of a prisoner who died at Elmley, another prison forming part of the Sheppey cluster of prisons, in November 2011. While it might not have prevented the man's death on this occasion, on unlocking cells staff should get a response in line with their training. We repeat the recommendation made in our earlier report into the death of a man at Elmley.

The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

Clinical issues

95. In his clinical review the reviewer says that:

”Throughout the man’s time in prison there was never an episode of psychoses and he always denied any self harm or suicidal ideations ...”

He also notes that during his time in prison the man had no medical problems other than an abscess in his mouth in July 2011, which was treated with antibiotics. He also notes that he was not seen by a health professional after his reception medical at Swaleside on the 16 September 2011, before his death.

96. He concludes that from a clinical point of view nothing could have been done to prevent the man's death as when he was found he had obviously been dead for some time and therefore was unable to be resuscitated. We agree with his conclusion that:

“The prison staff, and the nurse from healthcare in particular, acted in a very professional manner to a level which would have been comparable to that which would have occurred in the community.”

Delay in calling an ambulance

97. The man was discovered at 8.18am but an ambulance was not called immediately. The control room log records that the call for paramedics to attend was made when the nurse asked for an ambulance 8.22am. The investigator has been unable to confirm who requested the ambulance.

98. In his clinical review, the reviewer notes that,

“... an ambulance was not summoned until the man had been seen by a member of healthcare. Although it was academic in this case, prison staff should not wait for healthcare to attend before an ambulance is called, as vital minutes may be lost.”

It is essential that ambulances are called immediately in an emergency. Any delay has a significant impact on a person's chance of survival.

99. On 12 March, a week before the man's death the Governor of Swaleside issued the following Notice to Staff:

“If the injury/health matter is serious enough: Heart attack / Suicide attempt / Assault and it looks like hospital treatment will be required, staff should contact communications and request they call an ambulance for you. You do not need to wait for Hotel 1 [emergency medical response] to arrive for an ambulance to be called.”

Despite the notice being issued, an ambulance was not called until a nurse arrived at the cell. We therefore recommend that:

The Governor should ensure that all staff call an ambulance at the earliest opportunity in the event of an emergency.

Case history notes at Elmley and Swaleside

100. The man spent ten months in Elmley before being transferred to Swaleside in September 2011. During this time very few entries were made in his case history notes relating to the time that he spent at the prison. During one period of nearly two months, in spring 2011, no entries were recorded by staff at all.
101. We have drawn the Governor of Elmley's attention to poor recording of case history notes and in the wing observation book in two previous deaths in custody investigations at Elmley in 2010 and 2008. It is disappointing that so few entries were made during the man's time at the prison.
102. Similarly, at Swaleside, staff made few entries in his case history and two months passed in late 2011 when no notes were made at all. There were no significant entries made between 4 February and 18 March 2012.
103. We make the following recommendation to the Governors of both Elmley and Swaleside:

The Governors of Elmley and Swaleside should satisfy themselves that the all staff at their prisons are aware of the importance of completing quality and timely case history notes in P-NOMIS.

Press release

104. Following every death in custody, the Ministry of Justice issues a press release.
105. After the man's death a press release was issued at 4.52pm on 20 March. This was after his mother had been told the news of her son's death and visited in person by the liaison officer and other members of the prison's family liaison team. However, the press release unfortunately indicated that resuscitation attempts on him had been made by staff at the prison, although this was not the case.

The Governor should ensure all information given to the Ministry of Justice press office is accurate.

Hot debrief

106. A number of staff involved in the response efforts on 20 March were not invited to attend the hot debrief which took place. (A hot debrief provides staff involved an opportunity to talk through the incident. Its purpose is to establish what happened and to provide reassurance and support.) All members of staff should be invited to attend the hot debrief as it is a key part of staff support.

The Governor should ensure that all staff involved in a critical incident are given the opportunity to attend the hot debrief.

CONCLUSION

107. On his arrival at prison the man reported to staff that he had no concerns with regard to either his physical or mental illness, including depression, or any thoughts or history of harming himself. Although experiencing some difficulties while in Elmley, he settled well at Swaleside. He received regular visits from his family and spoke with his mother frequently. Officers who knew him spoke highly of him, as did other prisoners.
108. His actions appear to have been at odds with his behaviour and demeanour during his time at Swaleside up until 18 March, when he fell out with a friend on the wing and was moved wings. We conclude that his move to A wing was appropriate given the information available to staff at the time and we believe that staff at the prison could not have reasonably foreseen or prevented him from taking the action that he did.
109. Nevertheless, we identify a number of areas for improvement at Swaleside, particularly regarding weaknesses in roll check and unlock procedures, which meant that he was only discovered a lengthy period of time after his death and, even then, by another prisoner rather than a member a staff. Recommendations also address issues regarding poor recording practice (at both Elmley and Swaleside) and better emergency arrangements.

RECOMMENDATIONS

1. The Governor should ensure that staff working practices are not allowed to compromise the care, safety and security of prisoners and that staff carry out roll checks in line with requirements.

Accepted – *Notice to staff to be re-issued highlighting the correct procedures to be taken for prison roll reconciliation. All night staff to be informed and copy placed in duty information pack and for staff to sign to say they have read the instruction. Monthly team meetings managers to brief staff on correct procedures. Staff to sign to have read NTS and LSS reference safety and security of prisoners and roll requirements.*

2. The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

Accepted – *Weekly operation managers meetings and monthly team meetings managers to brief staff of the importance of ensuring a positive response when opening a cell door and recording on minutes. NTS to be issued and displayed in staff and wing information areas. Managers to emphasise on next SPDR review the importance of ensuring a positive response. Wing managers to complete quality check of staff knowledge.*

3. The Governor should ensure that all staff call an ambulance can at the earliest opportunity in the event of an emergency.

Accepted – *The report accepts that the local policy is appropriate but that it was not acted upon correctly on the day. Swaleside will be reissuing the policy highlighting the correct procedure to use when calling an ambulance. In addition copies of this should be displayed in all wing information areas.*

All night staff to be informed and copy placed in duty information pack and to sign to say they have read the instruction. Wing managers to complete quality check of staff knowledge.

To improve emergency arrangements defibrillators to be ordered and placed in wing main office, segregation and gym. Weekly checks to be completed by wing manager along with other health and safety routine checks.

Training initially given to wing senior managers this would be beneficial to improve confidence and dispel fears and can be delivered by the PE department with PE first aid instructors in a morning training session.

4. The Governors of Elmley and Swaleside should satisfy themselves that the all staff at their prisons are aware of the importance of completing quality and timely case history notes in P-NOMIS.

Accepted – *Swaleside – weekly operational meeting and monthly team meetings used to brief managers on the importance of timely entries. Wing*

managers' quality check. Notice to staff to be issued. Managers to emphasise on staff the importance of quality entries on prisoners case history notes.

Elmley – The head of residence will raise the importance of timely and accurate NOMIS entries at the next scheduled residential managers meeting. The residential principal officer will ensure this is discussed and noted at wing briefings. Notice to staff will be issued.

5. The Governor should ensure all information given to the Ministry of Justice press office is accurate.

Accepted – *Duty Governor should delegate a competent manager to the scene of the death in custody to collate relevant information concerning the incident with the first on scene, police and medical staff. Establishment's contingency plans to be amended to reflect this change.*

6. The Governor should ensure that all staff involved in a critical incident are given the opportunity to attend the hot debrief.

Accepted – *As part of the establishment's contingency plans. Hot debrief should take place directly after the conclusion of an incident. The care team should also be included and minutes to be taken including names for all attending. There may be occasions when some staff feel unable to take part in a debrief so close to the incident. Then they should be offered support and included in the cold debrief at a later date.*