



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP Risley in
April 2011**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the report of an investigation into the death of a prisoner at HMP Risley. Staff discovered him, in his cell, during the early morning count of prisoners on 2 April 2011, with a ligature around his neck. The man left a note explaining he had decided to take his own life because of the breakdown of his relationship with his wife. He was 25 years old. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. A review of the man's medical care in custody was carried out by a clinical reviewer on behalf of Warrington Primary Care Trust. Staff at Risley cooperated fully with this investigation. I apologise for the delay in issuing this report.

This report covers the events of the man's most recent period in prison when he was recalled to custody in January 2011 to complete a sentence originally imposed in September 2007. He died approximately three months later. Recalled prisoners are known to represent a heightened risk of suicide and self harm and this is recognised in Risley's own policy. An assessment of the man's risk as a recalled prisoner was not made. While there is no evidence that this omission contributed to the man's taking his own life a recommendation is made that the prison ensure such assessments of risk are made in future.

While reviewing the man's healthcare, the investigation found that a locum doctor had prescribed an antidepressant during a consultation with the man but had not recorded an assessment of his risk of self-harm or arranged for a further review of the prescription. Again, there is no evidence this would have made a material difference in the man's circumstances but could be important in other cases and a recommendation is made to address this issue.

The man was never subject to prison suicide and self-harm monitoring procedures, which was understandable based on the information known to staff at Risley. The report therefore concludes that they could not have reasonably predicted that he would take his own life, or prevented his death.

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 in June 2007, charged with actual bodily harm. Three months later, in September, he was sentenced to 33 months custody. Having initially spent time at HMP Durham, he transferred to HMP Lindholme where he completed some interventions to help address his offending behaviour but the Parole Board twice decided he remained a risk and unsuitable for early release.
2. In June 2010, the man was released to live at approved premises (probation hostel) in Cheshire. Records show that he complied with probation supervision and seemed motivated to change his behaviour. He received one warning while at the hostel for threatening other residents. The man later moved to live with his wife. In January 2011, following an alleged domestic incident, the man was recalled to custody.
3. Initially, the man was taken to HMP Altcourse but after a few days was transferred to HMP Risley. During interviews, he consistently denied any thoughts of suicide or self-harm and records show he seemed content to be at Risley. He quickly got a job working in the servery and seemed to settle into life at the prison. However, largely unknown to officers, the man was troubled by difficulties in his relationship with his wife and spent a lot of time trying to telephone her. He spoke to other prisoners about this and, on one occasion, an officer, but no one appeared to be aware how much his marriage troubles were affecting him. On 22 March, he told a doctor that he was feeling "stressed" about his relationship difficulties and was prescribed antidepressants. The doctor assessed the man's risk of suicide or self-harm as low, although he did not document this, and did not arrange a follow-up appointment.
4. On 2 April 2011, at around 6.00am the man was found hanging in his cell. The officer who discovered him was deeply distressed by what she saw and shouted to another officer who immediately raised the alarm over the radio. Staff were unable to attempt to resuscitate the man as he appeared to have been dead for some time.
5. A prisoner said that he had heard the man calling for help about 4.30am that morning. He said it took a prison officer about 20 minutes to arrive at the man's cell who then told him he would have to wait until the morning. No other prisoners or staff substantiated this. A police investigation concluded that there was no evidence to support this claim and we agree, not least because the man would have been dead by that time.
6. Being a recalled prisoner is a factor which increases someone's risk of suicide or self-harm, but the man had experienced this before and he consistently denied any thoughts of suicide or self-harm. The man did not disclose to anyone that his wife had filed for divorce. From the note discovered in the man's cell after his death, it appears that his actions, in apparently taking his own life, were in response to his inability to cope with the end of his marriage. Staff and prisoners were shocked by the man's death and no one had assessed there was a risk that he would take his own life.

7. The clinical reviewer concludes that the man's death could not have been prevented and the care he received in prison was equitable to that which he would have received in the community. While we agree the man's death could not have been foreseen we consider the lack of a documented assessment and provision for a follow-up appointment after prescription of anti-depression medication merits further action and we have made two recommendations.

THE INVESTIGATION PROCESS

8. The investigator was formally notified of the man's death on 5 April 2011. Notices were subsequently issued to both staff and prisoners at HMP Risley, informing them of the investigation process and giving them the opportunity to contact the investigator with any relevant information. A number of prisoners wrote to the investigator as a result. She later interviewed two of them and also several others who lived in the cells near to that of the man.
9. The investigator visited Risley on 7 April. She spoke to the Governor, family liaison officer, members of the Independent Monitoring Board (IMB) and the Prison Officers' Association (POA). The investigator was provided with the relevant documents for the man. She returned to Risley on 11 and 31 May to interview staff and prisoners. The delay in issuing this report is regretted. It was due partly to the delay in receiving the clinical review, compounded by workload pressures in this office.
10. Warrington Primary Care Trust (PCT) commissioned a review of the man's clinical care. The clinical reviewer's report was received in October 2011 and a copy is attached at annex 1 of this report.
11. The investigator spoke to a DC about the police investigation which concluded that there were no suspicious circumstances. The investigator also wrote to the local Coroner's office to inform them of the investigation. We will provide the Coroner with a copy of this report.
12. One of the family liaison officers, contacted the man's wife and his mother on 27 April 2011, to explain the purpose of the investigation and invite them to put forward any questions or concerns. On 9 May, the investigator and family liaison officer visited the man's mother and his aunt and uncle. The man's mother raised the following issues:
 - Why had it taken the prison six hours to inform her of her son's death via the local police and why did they not telephone her afterwards as promised?
 - Why had the man been recalled to prison?
 - Whether the man had tried to change his mind after trying to take his own life?
 - What did the man use to cut himself?

Although we may not be able to give the family answers to all their questions, we hope this report gives some insight into the man's time at HMP Risley.

HMP RISLEY

13. HMP Risley is a male category C training prison, for medium security risk prisoners defined as those who cannot be trusted in open prison conditions but who would not have the ability or resources to make a determined escape.
14. Risley has seven wings and a care and separation unit and can hold up to 1,085 prisoners. The prison offers a variety of work, vocational training courses and education. It has 24 hour healthcare cover provided by Warrington Primary Care Trust (PCT). During the day there is a doctor in the prison; at night, cover is provided by nurses.

Her Majesty's Chief Inspector of Prisons

15. The prison was most recently inspected by HM Chief Inspector of Prisons in February 2011. The Chief Inspector made the following comments:

“The prison has suffered historically from a poor reputation. At our last inspection in April 2008 inspectors found the prison was not performing sufficiently well in any area apart from resettlement ... There is still much to be done to ensure that the prison becomes a fully effective establishment that meets the range of prisoners' diverse needs ... Nevertheless, Risley is a much safer, cleaner and more decent prison than before...”

16. The Inspectorate noted that there was relatively little engagement between officers and prisoners on the wings and that prisoners said they had little involvement with their personal officers. Personal officer entries in prisoners' case notes were mostly observational and did not demonstrate active engagement and knowledge of prisoners' individual circumstances. Health services were generally regarded as satisfactory and the inspectorate assessed primary and secondary mental health services as good.

Independent Monitoring Board

17. Each prison in England and Wales has an Independent Monitoring Board¹ formed of volunteers from the local community. The most recent published annual report for the period April 2010 to March 2011 indicated that the Board had concerns about waiting times to see a doctor and there was a shortage of healthcare staff. The Board noted that more and more vulnerable prisoners were coming to Risley and there was a need for extra vigilance, but was satisfied that the prison took safer custody work very seriously.

Previous deaths at Risley

¹ The IMB is responsible for monitoring day-to-day life in the prison and ensuring that proper standards of care and decency are maintained.

18. Before the man, 11 prisoners had died in Risley since the Ombudsman became responsible for investigating deaths in custody in 2004. There have been a further three deaths since. In total, four of these deaths have been apparently self-inflicted, one was due to an assault and the remainder natural causes. There were no obvious similarities in the circumstances of these investigations.

KEY EVENTS

19. The man was born in April 1985. He had been diagnosed with depression in the community and prescribed anti-depressants before being remanded into custody.

June 2007 – 27 January 2011

20. The man was released from prison earlier in 2007 and subject to licence conditions. On 3 June 2007, the man was charged with committing a violent offence and was remanded to HMP Durham. On 17 September 2007, the man was sentenced to 33 months custody, with an extended licence period of two years. His sentence and licence were due to expire on 6 June 2012.
21. In October 2007, the man transferred from Durham to HMP Lindholme where he remained until his first release. At Lindholme, he completed the Enhanced Thinking Skills course in May 2008 and was noted to be motivated to change his behaviour, but in November 2008 the Parole Board found him unsuitable for early release because of the risk factors involved.
22. Subsequently, the man completed an alcohol awareness course, along with literacy, numeracy, hairdressing and catering qualifications. He was described as sometimes being abusive to staff, not mixing well with other prisoners and a “poor coper”. He received an extra 21 days in custody when he was found with a mobile telephone. In November 2009, the Parole Board again decided he was not suitable for release.
23. The man was released on licence, at the latest possible date, on 21 June 2010 to reside at approved premises run by the Cheshire Probation Trust. A report summarising his progress notes that he complied with supervision during this time and made good progress in terms of reducing his risk of general offending, developing pro-social attitudes and was relocated away from his negative peer group.
24. However, while at the approved premises, he received a warning for being drunk and making threats of violence towards other residents. The man subsequently moved from the approved premises to live with his wife.

28 January 2011 – 30 March 2011

25. On 28 January 2011, Cheshire Probation Trust requested the man’s recall to prison following an alleged assault on his wife. The allegation was not tested in court but the Probation Trust assessed that the man’s risk could no longer be managed in the community. The man was recalled to custody and taken to HMP Altcourse on 2 February.
26. On arrival at Altcourse, it was noted the man had no history of or thoughts of suicide or self-harm. An initial risk assessment on 7 February indicated he was unhappy about being recalled, and said the Probation Trust had lied about the reasons for his recall. He refused to sign the paperwork.

27. The same day, he told a member of staff that unless he was moved from his current wing he would stab someone. He later explained he had issues with some prisoners on the wing but refused to name them. The man said he was being picked on and having his tobacco stolen, would not be safe on any wing at Altcourse and asked to be moved to the Care and Separation Unit, as the segregation unit at Altcourse is known. (Segregation units provide temporary accommodation for prisoners that have become violent or disruptive, committed offences against prison rules, or require protection if they are under threat from other prisoners.) Although this is not documented it seems that the man was moved to the CSU as requested.
28. On 10 February, the man was transferred from Altcourse to HMP Risley. Risley has a First Night Centre/Induction Prisoner Passport which is a booklet that staff complete for each prisoner on their arrival. It has space for the prisoner's offence, sentence date and length to be noted but does not ask if a prisoner has been recalled to prison. It does flag up (on page 16) that being recalled to prison puts a prisoner at higher risk of self-harm. No issues were raised during the first night interview. The induction records indicate he was polite and co-operative and he denied any thoughts of suicide or self-harm. It was noted he was "happy to be at Risley". The chaplain also visited the man and recorded that there were no issues.
29. As a recalled prisoner, the man was added to the caseload of Probation Service Officer (PSO) an offender supervisor at Risley. (An offender supervisor is responsible for overseeing the management of an offender's sentence and their rehabilitation while in prison.) The PSO met the man on 23 February, to discuss the offender assessment, which had been completed when he was in the community and to explain what he could expect from the offender management unit. The PSO noted the man had a previous history of alcohol misuse and identified a need for alcohol work, although there was no alcohol worker at Risley at the time.
30. The PSO referred the man to the psychology department so that he could be assessed for the healthy relationships programme. He was found to be suitable for this programme but it was not available at Risley and therefore the man would have had to transfer to another prison to complete it and also to undertake victim empathy work.
31. After their initial meeting, the PSO said he expected to meet the man every month. The PSO said he met the man on a number of occasions after this and he was very subdued. The man thought it was unfair he had been recalled and had to complete more offending behaviour work to be released. The PSO described the man as "polite" but "not very forthcoming, didn't give much away".
32. After his arrival at Risley, the man quickly obtained a job in the wing food servery as 'pot washer'. An officer supervised the prisoners working in the servery and told the investigator that the man was an extremely good worker. He described the man as having a good sense of humour, polite, popular with staff and prisoners and would approach officers if he needed anything, in fact "the perfect prisoner". The officer said the only time he found the man worried was when

flowers which he promised to his wife had not been delivered to her. He had then allowed him to telephone his wife to explain. The officer told the investigator that he never had any concerns that the man was at risk of suicide or self-harm.

33. On 25 February, the man moved from D to E wing. Wing records indicate that following information received from the public protection unit, his risk of harm to staff and prisoners on his cell sharing risk assessment (CSRA) which was previously low was increased to medium. (The CSRA is an indicator of the risk a prisoner might present to another prisoner when sharing a cell.) The details of the information were not recorded. Staff noted the man was willing to share a cell and he was placed in a double cell, with a record that the situation was to be monitored.
34. The Parole Board considered the circumstances of the man's recall on 18 March and did not recommend his release. Cheshire Probation Trust indicated that the man should complete the healthy relationships programme before his release. The PSO said the man would have received this decision within a couple of days. The letter from the Public Protection Casework Section of the National Offender Management Service, informing the man of the decision, is not dated. We do not know when the man learned of the decision, other than it must have been between 18 March and 2 April.
35. Another officer told the investigator that shortly before the man's death she was assigned as his personal officer when he moved cells. (The personal officer scheme allocates a named officer to each prisoner who they can approach for advice or to resolve complaints.) She is normally personal officer to about nine prisoners. The man had asked the officer to move to this cell as it was a single cell on the south side of the landing. The date of this move was not documented.
36. The officer said that she had always found the man to be friendly and pleasant and he gave her no reason to be concerned for his welfare. She said he often socialised with other prisoners during their free time and did not have any issues of which she was aware. However, she did not have the chance to have an individual meeting with him.
37. On 22 March, the man attended an appointment with a locum prison doctor. He told the doctor that he felt stressed as his wife had told him she was considering divorce. The man was prescribed antidepressant medication (sertraline) which the doctor told the clinical reviewer was recommended for people suffering from a "degree of agitation or restlessness", which he considered applied to the man.

31 March and 1 April

38. Several of the prisoners spoken to, during the investigation, said that the man was worried about his relationship with his wife. He spent a lot of time trying to contact her or talking to her on the telephone. One prisoner heard the man talking to his wife on the evening of 31 March. He said the man seemed calm but "fed up". This prisoner described him as a "quiet man" who "kept himself to himself".

39. Another prisoner, had known the man when they were both in HMP Lindholme. He told the investigator that the man was disappointed to be back in prison and was worried that his wife had missed two of her visits. He said the man also found the regime harder at Risley than he was used to. The prisoner told the investigator that the man had been trying to contact his wife by telephone on 1 April, but managed only to speak to her mother who said she did not know where his wife was.
40. A second prisoner, told the investigator that the man had asked one of the other prisoners for some paper at around 3.00pm.
41. That afternoon, the man went to the prisoner's cell for a cup of coffee. He was disappointed he had been unable to speak to his wife and he talked to the prisoner about her. The man borrowed some magazines and music from the prisoner and then went to work in the servery. The prisoner said the man seemed more cheerful when he left his cell around 4.00pm.
42. The officer also spoke to the man in the afternoon when the man requested some clean t-shirts. Since the officer was finishing his shift, he told him he would get some the following morning. The man thanked him. The officer told the investigator that he did not notice any signs that the man was considering taking his own life.
43. Another prisoner told the investigator that, between 6.00pm and 7.00pm that evening, he spoke to the man for around ten minutes. The man asked him for a cigarette, which the prisoner gave him. He said the man seemed "okay" and did not mention any problems. He was not aware of the man having any problems with other prisoners and said he was often out of his cell as he worked in the servery.
44. Other prisoners also said they spoke to him that evening and had not noticed anything out of the ordinary in the man's demeanour. Some confirmed that the man had been worried about his wife and had made a number of telephone calls to her.
45. Prisons operate at night with a reduced staff, as did Risley. During night patrol state, only the senior officer in charge of the prison overnight (the night orderly officer, Oscar 1) carries a full set of keys to unlock all gates and cells. Wing staff and nurses do not have access to keys allowing them free access around the prison and have to be escorted. The officers and OSGs are each issued with a cell key in a sealed pouch for use in emergencies so that they can enter a cell where there is, or appears to be immediate danger to life. Staff are trained to radio the night orderly officer first and then make a judgement about whether to enter the cell or wait for assistance, taking into account security considerations.
46. Two officers were on duty on E wing overnight. They started their shift around 7.00pm and began by checking all the cells. The prisoners had been locked up at about 5.30pm as is usual on a Friday. One officer could not remember which particular cells she checked.

2 April

47. Another prisoner on the same wing as the man wrote to the investigator to say he had heard the man calling for help at 4.30am on 2 April. He said that a female prison officer went to the cell after 20 minutes and told him that she could not help him during the night. Both officers on duty said that this was not the case, that the man had not rung his cell bell, nor had he shouted for help.
48. The officer said only one cell bell was pressed that night. This was by another prisoner who wanted his night light switched off at 10.00pm. She added that the officers are expected to patrol every hour, apart from two hours, which means they have to walk around pressing the pegging points on the landing. This would mean they would have heard any cell bell and also a light in the wing offices would have been illuminated. The officer remembered another cell bell being pressed when a prisoner had a minor cut on his finger. The use of cell bells on that wing is not recorded electronically so it is not possible to make checks retrospectively.
49. The investigator interviewed a number of prisoners who were in the cells surrounding the man's. None of them confirmed the prisoner's assertions. Some said they heard loud music coming from the man's cell until the early hours of the morning and that the next noise they heard was the officers finding him.
50. At around 6.00am, the officers began the morning roll count to check that every prisoner was accounted for. The officer looked through the observation panel of the man's cell, saw he was hanging and shouted to the other officer. The officer told the investigator that she went straight to the other officer who was panicking, very distressed and could not immediately tell her what the issue was. She took the officer into the office and learnt that she had found a prisoner hanging. The officer telephoned the control room immediately and asked Oscar One, the call sign of the night orderly officer (who was in charge of the prison at night) to contact her.
51. A senior officer (SO) was the night orderly officer on duty overnight from 1 to 2 April and had responsibility for the security of the prison and for responding to any incidents. At about 6.00am, he received a telephone call from control asking him to contact E wing immediately. He did so and spoke to the officer who was distressed and could barely speak. He instinctively asked her whether there had been a hanging, which she confirmed. The officer then went to the cell and confirmed the man was hanging by looking through the observation panel.
52. Meanwhile, the SO ran towards the wing and radioed to Control "code black", meaning that a prisoner was unconscious. Control then radioed the orderly officer's assistant and the nurse responsible for responding to emergencies. He also requested control to call an ambulance.
53. The SO arrived on the wing a couple of minutes after receiving the initial phone call, closely followed by another officer, the assistant orderly officer, they looked through the observation panel and saw the man was hanging, having used a torn

bed sheet as a ligature. The SO immediately went into the cell and cut the man down. He removed the ligature from the man's neck and lowered him to the floor. The officer remained in the wing office and the other officer returned to check on her welfare.

54. The SO checked for signs of life but believed rigor mortis had set in. The SO observed three deep lesions on the man's left arm and a considerable amount of blood on the floor and walls. He assessed it would not be possible to resuscitate the man and radioed the control room to activate death in custody procedures. An officer remained outside the cell because of the amount of blood in the cell and the bed acting as an obstacle to him assisting the SO.
55. A nurse was on duty that night, based in the healthcare centre. On receiving the alarm she went immediately to E wing with emergency equipment, including a defibrillator. On her way, she was informed it was a "code black" emergency. The SO told the investigator the nurse arrived two to three minutes after him.
56. The nurse told the investigator that as soon as she went into the man's cell she knew it was too late to try to save him. She checked for signs of life, found no pulse and the man's pupils did not react to light when she shone a torch into them. The nurse said he was cold to the touch and rigor mortis had set in. The nurse noted that the bottoms of the man's socks were saturated with blood and there were footprints around his cell. She believed he had cut and then hanged himself. A record was made of the man's property but there was no indication as to what he used to cut himself.
57. The nurse and the SO noted all of the man's injuries. The SO found a note which the man had written stating his intention to kill himself which he safeguarded as evidence. He asked staff coming on duty to escort paramedics to the man's cell and that a partition be put up so that the cell remained private.
58. Once the paramedics arrived at around 6.20am, they attached the electrocardiogram (ECG) machine (used to monitor the electrical activity of the heart) to the man, shone a torch in his eyes and pronounced him dead. They estimated the man had been dead for a minimum of four hours.
59. The SO called the prison care team and tried to comfort the staff involved. The care team arrived and took them into a separate room. An extra SO was put on the rota for the following evening in case anyone was too distressed to work after the man's death.
60. Following the man's death, the prison family liaison officer, an operational manager and head of security, was contacted at home and arrived at the prison around an hour later. She and the Chaplain drove to the man's wife's home and informed her of the death of her husband.
61. During the visit, the man's wife gave the family liaison officer the contact details of the man's mother. When she and the chaplain returned to the prison, managers decided to ask the local police to inform his mother as she lived in the Durham area. The police informed his mother that afternoon and gave her the

family liaison officer's telephone number so she could contact her. At 7.05pm that evening, the man's mother rang the prison to ask why no one had telephoned her. The family liaison officer returned her call, apologised for the confusion, and explained she had been told to wait for her call.

62. The family liaison officer remained in contact with the man's family and, in line with prison service guidance, offered a contribution to the funeral costs. A few days later the man's wife visited the cell where he had died. All the man's property was returned to his wife. The man's funeral took place on 13 April.
63. Following the man's death, E wing prisoners remained locked in their cells during the morning but were told what had happened. The prisoners had a collection in the man's memory as a token of respect.
64. The SO said that staff involved were each spoken to individually later that morning by operational managers but that no communal hot debrief took place. The nurse said that the Governor and two managers had spoken to her, along with the SO but only to ask whether she had attempted CPR so that they could inform the man's family.
65. The two officers went straight to the Governor's office once they had finished giving their statements to the police, where they met the Governor in charge and an operational manager. They were asked what they wanted to do and they both opted to go home. A member of the care team was also present and took one of the officers home.
66. The SO said no one had contacted him regarding a critical incident debrief. However, he had felt adequately supported following the man's death. The nurse was also not aware of any critical incident debrief and said she would have found such a meeting useful. The officer also said she had not attended a critical debrief but had received the appropriate support.
67. After his death, staff recovered a letter from the man's cell from his wife's solicitor, dated 30 March. It informed him that his wife was initiating divorce proceedings and that he should not try to contact her. The man referred to this letter in the note found in his cell after his death in which he clearly stated his intention to take his own life as he felt unable to cope with the loss of his relationship.
68. The post mortem reported concluded that the cause of death was asphyxiation.

ISSUES

Recall to prison

69. The man had been released from prison a few months before he committed the most recent offence in June 2007. During his previous sentence, he had been recalled to prison and released at the latest possible date (his sentence expiry date). He had a history of offending and was familiar with the criminal justice system.
70. After he was released on licence in June 2010, the man complied with supervision and was reported to be making good progress for around seven months. However, following an alleged domestic incident, it was assessed that his risk could no longer be managed in the community and he was recalled to prison in January 2011.
71. Clearly, he was unhappy about this situation and asserted that the Probation Trust had lied about the circumstances for his recall. After his return to custody he appealed against the Parole Board's initial decision to confirm the recall. On 18 March, the Parole Board decided he should not be released. Unhelpfully, the letter informing him of this decision was not dated, and the prison have no record of when he was given it, so we know only that he received the news at some point in the two weeks before his death.
72. A recall to prison can be a factor which increases a prisoner's risk of suicide or self-harm. Risley's suicide and self-harm management policy instructs that interviews must take place with those recalled to custody to assess any issues of self-harm or suicide. As a recalled prisoner, the man was interviewed by his offender supervisor but this was in relation to his sentence management and not as an assessment of his risk of suicide and self-harm. Nor was any assessment made after the man received the news of the Parole Board decision of 18 March that he should not be released. There is little to suggest that the man's recall to custody affected him so deeply that he wished to take his own life. However, the decision to recall, and the confirmation of this which he received some time shortly before his death, cannot have helped his overall state of mind. In other cases it would be important to check the effect of decisions on prisoners. We therefore make the following recommendation:

The Governor should ensure that all recalled prisoners have an assessment of their risk of suicide and self-harm on arrival at Risley and after Parole Board decisions to confirm their detention in custody.

Assessment of risk of suicide or self-harm and clinical care

73. A review of the man's clinical care was carried out by a clinical reviewer on behalf of Warrington PCT. It was noted that during his imprisonment, the man had little contact with the healthcare services and had been assessed as having no significant physical or mental health conditions.

74. Several prisoners told the investigator that the man was worried about his relationship with his wife. He also said he found it difficult when he was unable to talk to her on the telephone or she did not visit him when he expected. The man spent a lot of time either on the telephone to his wife or trying to get through to her.
75. The officer who supervised the man in the servery, was the only staff member to mention these problems to the investigator. The officer said that he was aware the man was upset when some flowers which he had tried to send to his wife did not arrive and he therefore allowed the man a telephone call to her to explain why this had happened.
76. The clinical reviewer notes that on 22 March, the man was prescribed sertraline, an antidepressant. The man had told the doctor that he felt stressed due to relationship issues. The clinical reviewer was concerned that no assessment of the man's risk of self-harm or suicide was recorded at this appointment and no diagnosis or follow up appointment had been made in respect of the prescription of sertraline.
77. The clinical reviewer asked the doctor whether he had made any assessment of the man's risk of suicide or self-harm at this time. The doctor said that he had discussed, at some length, with the man how he was feeling and assessed him to be "fairly positive and determined". He did not assess the man to be a suicide risk and suggested he could talk to the chaplaincy about his relationship issues.
78. With regard to prescribing sertraline, the doctor explained that although he gave no specific diagnosis, he flagged up a clinical code on the computer system to indicate that the man was feeling stressed. He added that in general practice it is usual to follow-up such patients. In this instance, he did not do so as he did not expect the medication to be held in possession and he considered that the closed prison environment provides a safety net that enables observation by prison staff and quick medical attention if necessary. The clinical reviewer notes that this assessment should have been recorded in the man's medical record. In spite of the omission, he judges that on the basis of the information available, the man's risk appeared to be low.
79. The man does not seem to have disclosed the true extent of his concerns to prisoners or staff. As staff were not aware of the depths of his feelings, they had no reason to think that he was at risk of harming himself. Both staff and prisoners were shocked by the man's death and all had believed he was coping well with prison life.
80. The man had no history of self-harm or suicide and consistently denied any such thoughts when asked. It seems that, having received the letter from his wife's solicitor stating that their relationship was over and his wife was instigating divorce proceedings, he was unable to cope with this. The coincidence of the Parole Board decision cannot have helped. Unfortunately, he did not tell staff that he had received the solicitor's letter, or give any indication of the extent it had upset him, so they could not have predicted his intention to take his own life.

81. The clinical reviewer comments that his assessment was that the man's death could not have been prevented and makes no recommendations about his clinical care. The clinical reviewer concludes that:

“on the information available to me, I would say that on the whole the man received care which was of an equivalent standard to the care he would have received had he seen healthcare professionals in the community”.

82. Although in the man's case, the fact that there was no follow-up review of his medication did not impact on the man's care or the eventual outcome, it is important that assessments are fully recorded. The doctor accepted that in general practice in the community, a review would have been planned for patients prescribed with the antidepressant given to the man. We do not agree with his view that, instead of following his normal practice in the community, it was reasonable to assume that the custodial setting provided a safety net in which prison officers could be expected monitor prisoners' reaction to medication, particularly when they have not been identified as a risk. We therefore make the following recommendation:

The Head of Healthcare should ensure that doctors who prescribe antidepressants to patients note an assessment of risk and schedule follow-up reviews in line with practice in the community.

Emergency response

83. Having discovered the man hanging, the officer summoned assistance by shouting to her colleague on the wing, rather than using her radio to contact control as would be expected. However, her colleague immediately contacted the SO, who came to the man's cell straight away, followed by other members of staff, including the nurse on night duty. In any event, nothing could be done to save the man and paramedics estimated he had been dead at least four hours by the time he was found.
84. The officer's reactions were understandable. Seeing the man hanging in his cell surrounded by a substantial amount of blood was a deep shock. It is difficult to predict how staff will react in such a situation, particularly if it is the first time they have witnessed such a scene. It is fortunate that on this occasion the delay in staff entering the cell was not crucial. The SO reached the man's cell quickly and he and other staff cut him down immediately and checked for signs of life. However, often when a prisoner is found hanging every second counts and staff need to be aware that no matter how shocking the scene, their duty is to act calmly and respond professionally.

Allegations of the prisoner

85. The prisoner alleged that at 4.30am on 2 April 2011, he heard the man calling for help. He said a female officer went to his cell 20 minutes later and told the man that he could not be helped until the morning. None of the prisoners the investigator spoke to substantiated this claim, nor did either of the two officers on duty.

86. The investigator referred the matter to the local police who had access to the investigator's records and completed their own investigation. They found that the allegations were unfounded since no one else substantiated the prisoner's claims. They also concluded that if the man had been shouting for help, prisoners in cells closer to him than the prisoner would have heard, since the corridors would otherwise have been silent.
87. The police also noted that the man was hanging below the window, which was the furthest point from the door. They assessed that, if he had been shouting for help, they would have expected him to have been near the door. They considered the note found in his cell showed a clear intention to take his own life.
88. When the paramedics attended at 6.20 am they estimated the man had been dead for at least four hours. The time of his death would therefore have been about 2.20am, hours before the time the prisoner said he heard the man calling for help. It is possible that the prisoner heard one of the officers talking to another prisoner but neither recall this. It is unfortunate that there is no auditable cell call bell system on the wing which would have allowed this to be checked. We note the conclusion of the police on this matter and this investigation has found no other evidence to substantiate the prisoner's claim.

CONCLUSION

89. To those who knew him, staff and prisoners alike, the man appeared to be coping well in prison. He socialised with others, and had a job in the servery. He had no history of suicide or self-harm and during his time at Risley always denied such thoughts, including when given medication by the doctor to help with symptoms of stress.
90. Sadly, he appears to have concealed the depths of his distress about the failure of his marriage. According to a note found in his cell after his death, it was the loss of this relationship which led to the man being unable to cope and apparently taking his own life. We conclude that it would have been difficult for staff to predict or prevent the man's death.

RECOMMENDATIONS

1. The Governor should ensure that all recalled prisoners have an assessment of their risk of suicide and self harm on arrival at Risley and after Parole Board decisions to confirm their detention in custody.
2. The Head of Healthcare should ensure that doctors who prescribe antidepressants to patients note an assessment of risk and schedule follow-up reviews in line with practice in the community.

No	Recommendation	Accepted/Partially accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should ensure that all recalled prisoners have an assessment of their risk of suicide and self harm on arrival at Risley and after Parole Board decisions to confirm their detention in custody.	Accepted	All prisoners arriving at Risley have an assessment of risk of suicide and self harm as part of Reception and First Night / Induction procedures. This assessment and procedures in place will be reviewed - specifically in relation to Licence Recall Prisoners. Risley Safer Custody have already begun this review and have contacted NOMS OSRRG also for any national advice and recommendations.	31 July 2012	
2	The Head of Healthcare should ensure that doctors who prescribe antidepressants to patients note an assessment of risk and schedule follow-up reviews in line with practice in the community.	Accepted	<p>Risley Safer Custody Department have contacted Warrington Primary Care Trust regarding this recommendation and they have stated that they will respond with actions, recommendations once they have considered the full PPO Report. Action plan to be updated on receipt of proposed actions and recommendations from Warrington PCT.</p> <p>Update from Warrington PCT:</p> <p>When The man attended healthcare to see a General Practitioner (GP) he was assigned to a locum GP who was available that day. Locum GPs are often in attendance for just 1 or 2 sessions to cover absence. Prior to their commencement a short induction is provided to them.</p> <p>Bridgewater Community Healthcare NHS Trust – Warrington Division has recently undertaken a review of the GP service provision into Offender Health Services at HMP Risley and has restructured the service model. The new model ensures that a regular, permanent GP is available each day and that the need for locum GP use is restricted to unplanned sickness cover.</p> <p>The induction process has been adjusted to include advice on follow up arrangements following prescription</p>	31 July 2012	

			<p>of longer term medicines and the importance of documenting assessment of risk. Where possible, patient's who may require on-going appointments are assigned to the regular GP.</p> <p>The current GPs who work as part of the new service model meet regularly with the management team within Healthcare and also at Medicines Management meetings. This issue has been raised with the GP's who understand and implement the process. It is now scheduled to be raised as an agenda item for team discussion and formal acknowledgement at the next Medicines Management Meeting.</p>		
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