

**Investigation into the death of a young man
at HMYOI Rochester on 22 September 2004**

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

July 2006

This is the report of an investigation into the circumstances of the death of a young man in HM Young Offender Institution Rochester on 22 September 2004. He was found hanging in his cell just after 10 pm that night. Efforts by staff and paramedics to resuscitate him sadly failed. He was only 19 years old.

This report reveals how a series of mistakes and errors of judgement led to this tragic outcome. The man died while he was not lawfully held in custody.

My investigation team comprised two Assistant Ombudsmen, a Senior Investigator, an assistant investigator and a governor from HMP Swaleside. An independent review of the man's medical care in prison was commissioned from the Medway Primary Care Trust. Unfortunately, that report was not complete at the time of writing.

The Investigation Team would like to thank the former Governor and his staff at HMYOI Rochester for their assistance and co-operation during the course of this investigation. We are also indebted to the investigating officer from Kent Police for his very helpful involvement in the early stages of the investigation. I regret the delay in completing this report. This has been caused by several factors outside my office's direct control.

I have made a considerable number of recommendations, reflecting the seriousness of any young person's death and especially one that occurs in the circumstances described in this report.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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Summary

The young man who is the subject of this report was sentenced to a total of 12 months imprisonment in January 2004 for offences of violence and failing to surrender to his bail. He had been at HMP Chelmsford since 10 December 2003 and returned there upon sentence.

On 16 January 2004, the young man was transferred to HMYOI Rochester where he quickly settled into the routine of prison life. As part of his support plan, he had a number of one to one counselling sessions with a psychotherapist who worked for a charity called Starting Point, based in Maidstone. It was during these sessions that an attachment began to form between the young man and his counsellor.

The young man was released on licence on 9 June 2004 and went to live at an approved premises in Essex. A month later, he received a warning letter for returning late to the hostel, and at the end of July he was given a final warning letter. On 29 August, he returned to the premises late. Feeling that he would be sent back to prison, he packed his bags and left. When he missed an appointment with his Probation Officer on 1 September, the Probation Service notified the Early Release and Recall Section at Prison Service Headquarters with a view to having his licence revoked. The young man's licence was due to expire on 9 September.

His licence was revoked on 9 September 2004 and his details were listed on the Police National Computer for him to be arrested and returned to custody. There was no information making it clear that he could not lawfully be held in custody once he was returned to a prison because his licence had been revoked on the day it expired.

Unknown to the authorities, the young man had been living with his counsellor at her house in Sussex since he left the approved premises in Essex.

On 21 September 2004, a concerned neighbour called Sussex Police to the counsellor's address just after midnight. They could not find anyone but later that morning the counsellor arrived at Eastbourne District General Hospital with injuries she claimed had been inflicted by the young man. When police returned to her house at 10.47 am, they found him hidden in the loft. He had a large number of apparently self-inflicted cuts to his body. The Police Officers arrested him after a struggle and he refused medical treatment both at the address and later at hospital.

The police decided to return the young man to prison and question him at another time regarding the assault on his counsellor and, after a number of telephone calls, he was taken back to HMYOI Rochester. Once there he calmed down and allowed his injuries to be treated. The young man told the prison staff that he was happy to be there but would have killed himself if the police had not got to him in time.

A Self harm at Risk Form (F2052SH) was opened for him and it was decided that he should be checked every 30 minutes. He was put into cell C4-224 on C wing at 8.15 pm. At 9.45 pm, the Night Patrol Officer noticed that the cell observation panel in the cell door had been obscured. Other officers were called and the cell was entered. The officers found the young man in bed but noticed a torn strip of bed sheet hanging from the cell window. The strip was removed and the watch was increased to every 15 minutes.

At 11.10 am the next morning, 22 September 2004, Healthcare and prison staff carried out a case review in relation to his self-harm risk. The young man was present at the review and it was decided that he should be checked hourly from then on.

At 9 pm that night, the Night Patrol Officer saw the young man apparently writing on some paper in his cell. When he looked into the cell again at 10 pm, he saw him hanging by a strip of torn bed sheet from the cell window. Further assistance and an ambulance arrived but, despite efforts to resuscitate him, the young man died. The young man had left two suicide notes, one to his sister and one to his counsellor.

Investigation methodology

1. The investigation was opened at HMYOI Rochester on 24 September 2004. The Governor and his staff produced the young man's Core Record and a number of other documents for examination. Notices were issued to staff and prisoners informing them of the investigation. My investigator, was shown around the prison and discussed the circumstances of the young man's death with the Governor and his deputy. On subsequent visits, the investigation team requested and were given other documents and conducted interviews with prison staff.
2. A Family Liaison Officer (FLO) from the Ombudsman's office contacted the young man's family and offered them the opportunity to meet with that officer and an investigator to offer support, discuss the purpose of the investigation and to raise any concerns or questions that they would like explored and addressed. A meeting took place on 2 November with the young man's sister. The FLO also contacted the counsellor who agreed to meet with the FLO and an investigator to discuss her involvement and offer any support. That meeting took place on 23 November 2004.
3. I asked Medway PCT to carry out a clinical review of the healthcare received by the young man whilst he was in prison. A doctor was asked to prepare a report. Copies of the paperwork were delivered by hand to the doctor and a discussion about the case took place. Several phone calls to the PCT and the doctor have been made but no report has been forthcoming.
4. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, I will send this report to the Coroner to assist him in his enquiries into the death of this young man.

HMYOI Rochester

5. H M Young Offender Institution Rochester is a closed establishment that holds sentenced young men between the ages of 18 and 21 years who are serving less than four years imprisonment. The prison is able to accommodate 392 young men. During our investigation, the population of the prison was around 371.
6. The prison has a mixture of single and double accommodation cells contained on three Victorian wings and a further residential unit of single cell accommodation, which is used as an Induction Unit. This Induction Unit (C wing) was the unit where the young man was accommodated on 21 and 22 September 2004.
7. HMYOI Rochester had a new Governor in the same week that the young man died. He is placing a high priority on developing a performance culture, improving and developing the regime for prisoners and the environment for staff and visitors.
8. Rochester recently achieved a good rating in their Standards Audit inspection. The Security Audit was due to be held in March 2005. There have been no recent inspections by HM Chief Inspector of Prisons. The last inspection was in August 1999 when the prison was used for different purposes, housing adults, Immigration Act detainees, and young offenders, while C wing was used to house sex offenders under going treatment programmes.

The subject of this report

9. The subject of this report was born in 1984 in Dublin, Ireland. He was only 19 at the time of his death. He had an elder brother and two elder sisters. His parents separated when he was three. His mother suffers from schizophrenia and his father was given custody of him. The young man's elder sister left Ireland when he was seven, eventually settling in Essex.
10. The young man would stay with his mother from time to time and, in his sister's opinion, became adept at 'working the system' from an early age by observing his mother's involvement with Social Services. He truanted from school and did not complete his primary education, a fact his sister says did not raise much concern in Dublin. Despite that, he was a talented painter and musician.
11. At the age of 17, the young man went to live with his sister and started an apprenticeship with a local engineering company. He enjoyed the work and was doing well. The job brought money and with that the ability to buy alcohol. At a training course about six months into his apprenticeship, he got into a fight with another employee and was sacked.
12. The young man obtained a job at a nightclub in Colchester, which he enjoyed. Alcohol abuse was a problem for him and his inability to control his consumption of it lost him the job.
13. After staying with his sister and then with his brother and his girlfriend, a local housing association gave him a flat.
14. His sister was aware that the young man had self-harmed on two previous occasions. The first time he had taken an overdose of his brother's child's eczema medication. He became very drowsy and was taken to Casualty but suffered no lasting effects. The other occasion was when he had cut his wrists prior to a court appearance in December 2003. He had explained to her that it had been an attempt to obtain a psychiatric assessment to avoid being sent to prison. She said it was a typical example of him trying to use the 'system' to his advantage.
15. His sister was aware of the young man's relationship with his counsellor. It was probably the first serious relationship he had experienced. The young man was particularly impressed that she was a counsellor. He had said that he was very much in love with her. In his sister's opinion, her brother was completely obsessed with the counsellor. His sister showed my investigator the young man's mobile telephone and the text messages on it both to and from the counsellor professing their love for each other.

The young man's family

16. The young man's sister said that her parents did not have any questions or concerns regarding his death. They have visited Rochester with her and her other brother. Her parents were impressed with the establishment and the staff. His sister explained that they had been expecting something much worse, assuming that all prisons were like the prison in Dublin. The Governor had shown the family around the prison and allowed them time in the cell that the young man had occupied. They have no complaints about the way staff treated them.

17. His sister said that she had not known about the torn up bed sheet being found in his cell the day before he died. She was also concerned about the time that he had died, as she was worried that he had wanted to be found. She was reassured when my investigator said that it looked as if the young man had killed himself shortly after 9 pm knowing that staff would not be returning until 10 pm.

Events prior to the young man's death

18. The subject of this report had been convicted of a number of minor assaults, public order and damage offences dating from November 2002 until December 2003 for which he had received community rehabilitation orders. He had remained at liberty partly in light of an assessment report for Colchester Magistrates' Court prepared by a Consultant Psychiatrist.
19. The young man had told the psychiatrist that he had self-harmed from the age of 13 and had 'died twice' and had to be resuscitated in hospital, once from cutting his wrists and once from an overdose. He also said that he cut himself frequently when distressed. This information which came from the young man is more extreme than the information supplied by his sister to my investigators.
20. On 9 December 2003, the young man was arrested for failing to answer his bail on 1 December. A doctor saw him at the police station and noted scars from apparently self-inflicted cuts to his face and wrists. At Colchester Magistrates' Court the following day, he was seen by a member of the Criminal Justice Mental Health Team who noted numerous old cuts to the young man's face, wrists, chest and stomach. His strong suicidal ideation and intention was also noted, as well as the young man threatening to further self-harm if remanded in custody.
21. The Court remanded him into custody on 10 December 2003 and he was sent to HMP & YOI Chelmsford. The committal warrant has a hand written note on it stating, 'N.B serious risk of self-harm + suicide. Suicide watch to be implemented.'
22. Chelmsford opened a F2052SH booklet upon his arrival at the prison. The concerns of the Court staff were noted and he was put into a double cell as well as being given access to 'Listeners' and the Samaritans' phone. (Listeners are prisoners who volunteer for training by the Samaritans to provide support to other prisoners.) The young man remained in a shared cell throughout his time at Chelmsford. His Cell Sharing Risk Assessment (CSRA) assessed him as a medium risk, defined as 'no immediate risk but the situation will need to be reviewed regularly'.
23. During his First Reception Health Screen he said that he had cut himself deliberately many times in the past and had attempted suicide by overdosing, hanging and cutting his wrists. On the same page of the form, he declared that he was feeling neither suicidal nor having thoughts of self-harm. He also said that he was not using drugs. It must be understood that the prisoner supplies the information for this form and, at the time of

completion, the nurse usually has no means of verifying that information. Despite his replies he was kept on the F2052SH booklet.

24. On 22 December 2003 at 2.20 am, the young man made cuts to both his forearms requiring sutures and the application of Steri-strips. He was placed on a 15 minute watch for a short time. The self-harm is not referred to again on the F2052SH and there appears to have been no review after the incident. Furthermore, at the review on 30 December it is not mentioned.
25. The young man attended Colchester Magistrates' Court on 9 January 2004 and was sentenced to 12 months imprisonment. He returned to Chelmsford but was transferred to Rochester on 16 January to serve the remainder of his sentence. The Senior Officer (SO) in charge of the reception area that day completed a Cell Sharing Risk assessment form. He noted that the offence that the young man was in custody for was ABH and that he had a homophobic tattoo on his chest. The young man also said that he did get angry and frustrated quickly and that it was immature behaviour relating to his family. The SO ticked NO to the entire list of anti-social behaviour in section 2 of the form. Nothing appeared to have changed since 10 December 2003, yet the young man was identified as a high risk of harm to others and therefore allocated a single cell.
26. There had been no incidents of self-harm since 22 December and the young man stated that he was not feeling suicidal and was keen to come off the F2052SH booklet. His case was reviewed on 20 January 2004 and the booklet closed. As part of the prison's continuing support, he was referred to Starting Point, a charity working with young and adult offenders and their families, for counselling.
27. The young man began to attend one to one counselling sessions in the Healthcare unit with a psychotherapist who worked for Starting Point. His first session was 28 January and he had a session almost every week until 2 June 2004. There was a total of 18 sessions.
28. His counsellor had been a volunteer counsellor at Rochester for Starting Point since August 2002. In October 2002, the Health Care Manager, sent a memo to the Deputy Governor regarding concerns about a young prisoner and the way that prisoner behaved around female staff generally and the counsellor in particular. The young man had been observed inappropriately crowding the counsellor's personal space following a counselling session. The healthcare manager wanted to move the venue closer to where other staff would be able to monitor and supervise the sessions. It would seem the counsellor reluctantly agreed.
29. During interviews, three people who saw the sessions conducted by the counsellor told my investigators that they had cause to voice concerns to the healthcare manager. These concerns centred on her sitting close to her clients during the sessions and the fact that some clients knew quite a lot about her family and personal life, which staff felt was inappropriate.

The healthcare manager did not either raise those concerns with the counsellor or investigate further.

30. In February 2004, Rochester considered the young man for release on Home Detention Curfew (HDC) but on 26 February it was refused. The reasons for refusal were that he had previously failed to surrender to bail, previously offended whilst on bail and had two findings of guilt at adjudication. The most recent adjudication was on 11 February when he had refused to go to work. Previously, fermenting liquid (an attempt to make alcohol) was found in his shared cell at Chelmsford.
31. The remainder of his time at Rochester passed without incident and the counselling sessions continued.
32. On 9 June 2004, the young man was released on licence under the Automatic Conditional Release (ACR) scheme, having completed half of his sentence. He lived at an Approved Premises in Essex. That was not a condition of his licence but he was required live where "reasonably approved by (his) supervising officer and notify him/her in advance of any proposed change of address." His licence was due to end on 9 September 2004.
33. The Deputy Manager of the premises described the young man as a cheeky, charming, irritating, young man who would make you frustrated one minute but the next he would be bouncy and happy again. She said that the premises were run as a "tight ship" but staff would bend over backward trying to make a difference to the lives of residents.
34. The young man was very anxious all of the time he was at the approved premises. He wanted to get his licence over successfully but was worried that he would be recalled and this became more and more of an issue for him. After the slightest misdemeanour, he would ask, "I'm not going to be recalled am I?"
35. On 28 July 2004, following his involvement in a fight, the Assistant Chief Officer (ACO) sent the young man a Final Warning letter. Although the staff would have been warned that this was coming, the young man was not required to open it in their presence and his reactions were not observed.
36. The Deputy Manager said that, on the afternoon of 29 August, the young man had been feeling very wound up. She spoke to him and lent him a cd telling him to play it in his room and relax for an hour or so. He was exhibiting a high level of anxiety as he often did, wanting his licence to end so that he could rejoin his family and rebuild his life. The Deputy Manager did not see him again.
37. That night, the young man returned to the approved premises 40 minutes late for curfew. When he asked if he would be recalled, the member of staff on duty said he could not say what would happen but he

would have to report it up the line and it would be for others to make the decision.

38. However, at 2.50 am on the morning of 30 August, the young man's room was found to be empty. He had taken his belongings and left the premises. There was no condition of residence. If there had been, when staff found the young man was absent after curfew they would have contacted the stand-by Manager who in turn would have discussed the situation with the stand-by ACO. If it was thought that there was significant risk to the public, then the Early Release and Recall Section in the Prison Service would be contacted immediately. In this case, the supervising officer was informed as she retained responsibility for managing the licence.
39. The Deputy Manager said that during the period that the young man was absent, she had several telephone conversations with his sister who was very concerned about him. She urged the sister to tell him to return and he would not be recalled. She described, "constant telephone calls back and forth" to the sister but she did not speak directly to the young man. If he had returned, every effort would have been made to avoid having him recalled, as the end of his licence period was so close.
40. As it was, Monday 30 August was a Bank Holiday, and the supervising officer was not in the office again until Tuesday 31 August. The young man had left a message on her answerphone to tell her of his intention to return to Ireland and saying he was at Holyhead. The supervising officer was a Trainee Probation Officer and, before making a decision about what action to take, she consulted her line manager and the approved premises. She confirmed that there were no plans to breach him at present, although there would be if he went to Ireland, and that the hostel would take him back if he returned. She could not get through directly to the young man on his telephone so left a message for him, urging him to return.
41. The young man was in breach of his licence by failing to inform the supervising officer in advance of a change of address but he had an appointment to see the supervising officer the following day, 1 September. With the approval of the Senior Probation Officer, she decided to give the young man the opportunity to contact by waiting until then to see if he reported. When he failed to do so, he was further in breach of his licence and steps were taken to inform the Early Release and Recall Section (ERRS).
42. The young man was not considered a high risk to the public. The information was not processed as an urgent case, and immediate recall was not requested. If it had been, the ERRS would have acted more quickly. (Immediate recall is requested only if there is considered to be a high risk to the public or self by the offender.)
43. The young man had been serving a 12 month sentence. Sentences of 12 months up to, but not including 4 years, fall under Automatic

Conditional Release (ACR) procedures. Prisoners are automatically released on licence at the halfway point of their sentence, assuming they do not get earlier release through Home Detention Curfew. The licence period runs from the day of release to the three-quarter point of their sentence. The remaining quarter is not under supervision, but the person is 'at risk' of having to serve that portion of their sentence if they are convicted of a further offence during that period.

44. The young man's period on licence started at 00:01 hours on 9 June 2004 and lasted until 00:00 on 9 September 2004. In practice, prison establishments cannot release a prisoner at midnight on the day that their licence expires and so release them instead at some time during the day before.
45. My investigation team met with several members of ACR Section in Croydon and were told of the normal recall procedures and timescales set. The target number of days from receipt of a fax instigating breach proceedings to receiving a reply from the Parole Board is five working days. This equates to one day to receive the request from probation, one day to draft reasons for the Parole Board to consider, one day to send the paperwork to the Parole Board and two days for the Parole Board to convene, consider and communicate their result back to ACR section. The licence revocation is normally issued the same day that the results are received back from the Parole Board.
46. On 2 September, the Probation Service sent a fax to ACR section in Prison Service Headquarters saying that the young man had breached his licence conditions and that they were therefore instigating recall procedures. The fax was sent at 11am. No action was taken that day by ACR section.
47. On 3 September, the fax was booked in and identified as requiring 'fast track' procedures. The reasons for the Parole Board to consider were drafted. No further progress was made over the weekend of 4 and 5 September.
48. On Monday 6 September, the application for licence recall was sent to the Parole Board for approval. The Parole Board sat on 7 September and approved the recall. The results of the Parole Board are normally sent to ACR section the following day. These were duly e-mailed on 8 September at 09:00 to the head of ACR section who then copied them to team leaders at 09:42. Caseworkers in the team are then informed of the results. The identified caseworker was not in the office that day; he was working at another office in central London. No one picked up his work and no one processed the young man's licence revocation. The failure to act on the Parole Board's decision meant that ACR Unit did not meet their target of five working days to process a Licence Revocation. More importantly in this case, it meant that when the licence revocation was issued on 9 September, there was no longer any time left to serve in prison custody before his original licence expired.

49. On 9 September, the caseworker returned to the office and completed the licence revocation for the young man. The revocation was sent to Scotland Yard and noted on the Police National Computer in the normal way. There was no note on the Licence Revocation indicating anything unusual about this revocation. The revocation notice stated, "the Secretary of State hereby revokes the licence issued on 9/6/04 in respect of and recalls him to prison... signed on behalf of the Secretary of State 9/9/04." The revocation paperwork explicitly states that the named individual is being recalled to prison. There was no way that police detaining the young man, nor a receiving prison's reception staff, could identify that the Licence Revocation had been issued on the same day the initial period on licence expired and that therefore there was no lawful period left to serve in custody.
50. It is now known that the young man and the counsellor had met up shortly after his release from Rochester and had spent a lot of time together thereafter. He had been with the counsellor during 29 August and the early hours of 30 August. Having returned late to the approved premises in Essex and fearing that he would be 'breached', the young man telephoned the counsellor. She collected him and took him to her house in Sussex.
51. The counsellor allowed the young man to stay with her at her house. She says that they were in love and he was there as her partner. He lived with her and her children until his arrest.
52. Just after midnight on 21 September 2004, Sussex Police received a telephone call from the counsellor's neighbour. She was aware that a young man was living with her and was concerned for her safety. Police attended the address and saw signs of a disturbance but neither the counsellor nor the young man were present. Later that morning, the counsellor contacted the police from Eastbourne District General Hospital, where a motorist who found her after she had fled her house had taken her. She told the police that the young man had assaulted her.
53. At 10.47 am on 21 September, Police Officers returned to the counsellor's address and eventually found the young man hiding in the loft. They saw blood and pieces of razor blade around the house. The young man was bleeding from multiple apparently self-inflicted cuts to his arms and torso. The Officers managed to detain him after a struggle and, realising that he required medical treatment, called an ambulance. He refused to let the paramedics treat him. He was eventually taken to Eastbourne Hospital where he again refused treatment and had to be restrained. Eventually he allowed some rudimentary bandages to be applied and the Police Officers took him to Eastbourne Custody Unit arriving just after 1pm.
54. The young man was kept in the police van because of his volatile behaviour whilst the Custody Officer contacted both Lewes Prison and

Feltham YOI in an effort to return him to custody as required by the licence revocation. Lewes refused because of his age. Feltham would have accepted him if he had been arrested in London, but as he was in Sussex suggested that he be returned to Rochester.

55. It should be noted that the licence revocation document did not indicate that the prisoner should have been taken to a prison, immediately issued a new licence, and released. Nor that any detention upon arrival at the prison would be unlawful. The entry on the Police National Computer regarding the licence recall merely gave a telephone number at ERRS to contact. When contact was made, the officers were not made aware of the situation relating to the young man's licence, but were faxed a copy of the licence revocation notice. The notice carries no information about when the licence expires.
56. The Custody Officer at Eastbourne telephoned Rochester and spoke to an Administrative Officer (A.O) who works in the Custody Office. Her main job is to carry out the sentence calculations and confirm discharges. She does not have the authority to agree to accept prisoners so she rang Reception and spoke to the SO. He told her to tell the police to bring the young man and asked the AO to get his back record brought to Reception. The investigation team were told by the Deputy Governor that, at Rochester, such a decision should have been made by the Orderly Officer. Once the young man arrived, the decision to let him stay was taken by a more senior officer.
57. The young man arrived at Rochester about 4 pm. He was taken to Reception and into the medical room. He stated that he would have killed himself if the police had not arrested him. Shortly after the Deputy Governor attended and spoke with the Police Officers and the young man. He said that everyone looked tired, the young man was dishevelled and dirty and already being treated by a Healthcare Officer. The Deputy Governor believed that the young man had been taken to Lewes and Feltham before arriving at Rochester. The young man was calm and stated that he was happy to be back at Rochester. The Deputy Governor says that he then decided on compassionate grounds that the young man should stay.
58. The nurse opened a F2052SH at 5.45 pm stating on the form, '..... was brought into Rochester under Police escort, with numerous self inflicted cuts to both arms, upper body, face and neck. Says he is happy to be here but would have killed himself if the Police had not got to him in time.' At 5.50 pm, she made another entry in the healthcare assessment section, 'States he is happy to be here and will not self harm again.' At that time she also decided that he should be housed on C wing and in a single cell.
59. The police had documented a total of 14 injuries to the young man's body, a few scratches but mostly cuts of varying length and depth. It was decided that two of the cuts would require suturing by the prison doctor.

The doctor gave the young man 10 mg of Olanzapine, a mild anti-depressant that he had previously been prescribed at Rochester. Another SO saw the young man when he was in the healthcare unit at about 6.30 pm as his cuts were being sutured. The officer spoke with him for about 30 minutes during which time he was calm and stated that he did not intend to kill himself nor cause himself further harm. He also acknowledged that he would have to serve the remainder of his sentence. The young man thought that he would remain in custody for a further three months.

60. The doctor made an entry in the F2052SH booklet at 7.45 pm stating, 'Multiple lacerations to trunk and forearm. Did it 03.00 hrs today. States "was drunk" at the time. No self harm, suicidal intent.' She also ticked the box for him to return to a Residential Unit as opposed to the Admit to Health Care Centre option. In the case of Rochester, which does not have the facility to offer in-patient care, prisoners need either to be transferred to nearby HMP Elmley, which has 24 hour Healthcare, or to a NHS Hospital. The Healthcare staff at Rochester are on duty until 9 pm.
61. The reception SO said that, even though a formal Cell Sharing Risk Assessment was not carried out, he remembered that the young man was assessed as a high risk previously and would have assessed him so again. As a 'high risk' prisoner, the young man would not have been put into a shared cell.
62. The second SO then made some entries in the F2052SH booklet that had been opened. He wrote, 'This prisoner had several serious self harm wounds that needed stitching by the duty doctor, there were slashes and cuts all over his torso, arms, forearms, neck and face. Police took him to hospital for treatment but he refused.' He then listed his decisions about how the young man was to be managed on the F2052SH:
 - 30 minute watch until seen by outreach team for review.
 - Prisoner to be kept in a single cell until reviewed
 - Samaritans phone to be made available when requested.
63. During interview, the reception SO admitted that neither a First Reception Health Screen form nor a Cell Sharing Risk Assessment were completed for the young man. These are important documents normally completed shortly after a prisoner's arrival in Reception. The former asks a prisoner a number of questions about his health, state of mind and other medical or addiction problems he may have, the latter is used to consider the level of risk of putting the prisoner in a cell with another person.
64. The young man was allowed to make a telephone call whilst in Reception at 8.10 pm. He rang the counsellor's mobile number, which her ex-husband answered. It is believed that he told the young man not to call again and hung up.

65. At 8.15 pm, the young man was put into cell C4-224 on C wing, the induction wing. The cell is on the top landing at the end of the spur, furthest from the stairwell and the wing office. The windows in the cell have secondary glazing which slides open to allow access to the small top windows that can be opened by use of the metal finger loop handles. There had previously been two notice boards fixed to the walls of the cell. These had been removed but the curved brackets, about three inches long, two top and two bottom, had been left. The metal bed was bolted in place and there was a fixed metal sink and toilet. A small wooden table, a wood and metal chair and a wooden cabinet with a television on top completed the furniture. There is no evidence to suggest that any consideration was given to which cell the young man was put into, other than what was available.
66. At 9 pm, the Officer Support Grade (OSG), the Night Patrol, looked into the cell. He was looking out of the window. The OSG asked the young man if he was ok and he replied "Yes". At 9.30 pm, when the OSG went to recheck the young man as required by the F2052SH protocol in place, he saw that he was in bed, apparently asleep but that the inspection window in the cell door was partially blocked. He contacted the night duty SO by radio to inform him of the situation.
67. The SO arrived on C wing shortly afterwards with other officers. The SO saw that the window had not been completely blocked but it made viewing into the cell difficult. The SO spoke to the young man, who appeared asleep, through the door. He got no verbal response, although he did move. The SO unlocked and entered the cell and spoke to the young man, who was very sluggish. He told him that the window had to be kept clear and the young man just grunted in reply. The SO pulled the blanket down to the young man's waist to check his injuries and, noting that all appeared in order, he turned to leave.
68. It was at that point that he saw a torn piece of bedding hanging from the window. It was about one inch wide and about four feet long and had been wedged between a wooden batten that was part of the window and the wall. Although it was not fixed securely to anything, The SO realised that it could be used as a ligature for self harm and removed it from the cell. He did not attempt to speak to the young man about his find. Back in the C Wing office he wrote up the incident in the F2052SH booklet and appropriately increased the watch to be kept on the young man to 15 minutes. There were no further incidents that night.

22 September 2004

69. The young man woke shortly after 8.15 am on 22 September. At 8.45 am, he was asked to get ready to go to Healthcare. He was non-communicative and at 9.15 am a nurse and a health care worker (HCW) went to his cell. The nurse, who knew the young man fairly well, explained that they had to do a case review. She says that he was unwilling to go over to Healthcare but willing to talk to them. He said he was very tired and they agreed to return at 10 am.
70. At 10 am, an officer wrote in the F2052SH booklet, 'Remains uncommunicative and will not get up.'
71. The nurse and the HCW returned to the young man's cell at 10.30 am and they persuaded him to get out of bed and co-operate. He did not go to Healthcare. There is no mention of this interaction with him in the F2052SH booklet.
72. A short while later, a F2052SH case review was held in the SO's office on C wing. The nurse was present along with a Principal Officer (PO), an SO, the HCW and the young man. All of the staff say that he presented well during the review, acknowledging why he was there and generally taking part in the process. When asked specifically about the ligature found the previous night, he said that he had done it out of boredom and shrugged it off. He said that he had assaulted his girlfriend and cut himself quite badly. The young man said that alcohol played a big part in the events. He did not divulge who his girlfriend was. The young man said that he wanted to be at Rochester, he felt safe and that he knew he had support there. During the review, he was asked about his first night phone call and he said that he had telephoned his girlfriend. He said that he had not spoken to her as her ex-husband had answered. He said that he asked the ex-husband to pass on a message to say that he was sorry. He did not refer to the call again.
73. The nurse wrote up the case review in the F2052SH booklet at 11.10 am. In the summary she wrote, 'Tied a ligature to the window as was fed up about the situation with his girlfriend.' The review team decided on the following support plan for the young man:
- F2052SH to remain open following protocol
 - To be observed hourly when in cell
 - Wing to arrange phone call to sister
 - Outreach to visit and support daily
 - Aware of Samaritans phone if needed during the night.
74. Meanwhile, the AO in the Custody Office was processing the twelve sets of documents for the new prisoners who had come to Rochester the previous day. She now believes that the young man's file had been placed into his back record the previous night in reception and had been sent to

Security. She attended a meeting in the late morning and, when she returned to her desk at lunchtime, the young man's file was there. However, her work schedule is to process the new intakes in the morning and discharges and other work in the afternoon. She placed his file into her morning tray to be processed the following day. The AO officially had 48 hours to process the file and she would have been within that time limit. No one at the prison was therefore aware that the young man could not lawfully be held in custody. He should have been released with a new supervision licence.

75. The Healthcare staff told the Deputy Governor that the young man's girlfriend was his Counsellor. The police had notified the staff. The Deputy Governor decided that he needed to speak to the young man about that and sometime during the afternoon he and a Principal Officer (PO) spoke to him in his cell. The Deputy Governor explained that the prison was aware of whom his girlfriend was and that she would be excluded from the prison in her official capacity. However, he said that if she wished to visit him as a friend that would be allowed. The young man was apparently very non-committal about that but generally was calm, chatty and compliant. The Deputy Governor thought that he looked a lot better than when he had seen him the previous evening. The young man said, "Thanks for keeping me, I am feeling OK."
76. The Deputy Governor has said that, due to the confidentiality of the issue regarding the counsellor, he did not make an entry in the F2052SH booklet.
77. Also during the afternoon, Sussex Police contacted the prison and told them that the young man had written 'F*** your clients' on a wall at the counsellor's house. No Security Information Report (SIR) was generated as the result of this information. A wing officer made an entry on the wing book stating that the young man was to be accompanied at all times whilst off C wing, except when on visits. The reason was the possibility of him wanting to harm other prisoners who had been counselled by his counsellor, out of jealousy. This entry was dated but not timed. A later entry added by the PO read, 'This young man is not to try to contact his ex-girlfriend who is allegedly a possible victim.' Again, the entry is not timed.
78. During the rest of the afternoon, the young man took some exercise and had some time to associate with other prisoners. He told staff that he was fine and that he knew that there might be some consequences of his actions against his girlfriend.
79. At 6.50 pm, an outreach worker was on C wing and the young man asked to see her. She spoke with him for a few minutes during which he expressed concern for the counsellor and started talking about how guilty he felt about everything. The outreach worker, who knew the young man well, told him that she would see him later in the week. An hour later, he was out on the wing for association before lock-up for the night.

80. At 9 pm, the night patrol OSG looked through the observation panel into the young man's cell and saw that he was writing on something. He had a pen in his hand. He asked how he was and he replied, "Yes I'm fine," and gave the officer the 'thumbs up' sign. It now seems likely that he was writing out his suicide notes.
81. Probably after that check, the young man broke off one of the window openers and used that to remove the wooden surround to one of the window panes. He then took the pane out completely. He placed it out of sight at the head of the bed and put the pieces of wood and the window opener in the cabinet by the door.
82. At 10 pm, the OSG again looked into the cell. He saw that he was hanging from the window at the rear of the cell, and appeared lifeless. The officer walked back to the stairwell so as not to alert the other prisoners. He used his radio to notify the control room that he had a 'hanging'. Believing there was nothing he could do to get the young man down, the officer returned to the wing office. As he arrived, the night SO and other officers came onto the wing.
83. As they got to the cell, another officer who had been on patrol joined them. They saw that the young man was hanging from the window, his lips were blue and there was no movement. An officer opened the door, and the SO held the young man to relieve the pressure on his neck and asked for someone to use the scissors to cut him down. It was then that they realised that the OSG had brought the First Aid green box from the wing office, not the cut down green box. An officer ran to get the scissors from the cut down box in the wing office. Meanwhile, the first officer used his lighter to burn through the ligature and the young man was moved onto the floor in the corridor as it afforded more space in which the officers could work. The officers commenced Cardio Pulmonary Resuscitation (CPR).
84. The Control Room staff had telephoned at 10.08 pm for an ambulance that arrived at 10.26 pm. It had been delayed for a few minutes as the crew had gone to HMP Cookham Wood, the women's prison on the same estate. The crew then spent some time looking for HMYOI Rochester, before being directed by their radio controller.
85. When the Paramedics arrived on C wing, they noted from observing the young man's skin colour that the CPR was ineffective. In the opinion of one of the Paramedics, he had been dead for about 30 minutes. They attached an automatic defibrillator and got a 'No signs of life' read out. A larger machine was then taken from the ambulance and attached so that a readout could be obtained. It was left in place for 10 minutes after which they completed a life extinct form.
86. The young man's body was screened off, the police were called and his cell sealed.

87. The young man had written two suicide notes. One was to his counsellor, saying sorry for everything including what he was about to do and professing his love for her. There was a similar note to his sister but asking her to contact the counsellor and to tell her he loved her.
88. Various senior staff came into the prison as a result of the young man's death, including the new Governor. A de-briefing session was held about 3 am. Members of the Care Team also attended. All of the staff interviewed were happy with the level of support offered that night and subsequently.
89. A notice was displayed where staff collect their keys announcing the young man 's death. Some staff thought that was not the best way to learn of the tragedy but could not think of a viable alternative.
90. The prison complied with the contingency plans for a death in custody.
91. The Governor made contact with the young man's family and invited them into the prison. The family made a trip from Ireland to the prison and spent some time in the young man's cell and on C wing. When my investigators spoke with his sister, she said that the family were very happy with the Governor's response and the way they had been treated.

Evaluations and conclusions

Licence revocation

92. The only person who was aware that issuing the Licence Revocation on 9 September meant that the young man could not be held in prison custody was the case worker in the ACR unit. He did not communicate that fact.
93. Given the unusual circumstances, it is surprising that the case worker did not seek further guidance on dealing with the young man's revocation from his line manager and/or the head of unit.
94. Neither the police detaining the young man, nor HMYOI Rochester's reception staff, could reasonably have been expected to know or find out that he could not lawfully have been held in prison on 21 September.
95. The young man took his own life on 22 September, before the Custody Office at Rochester had calculated his revised release dates (when it would have become apparent that he should not have been in custody).
96. Whether the young man would have been held in custody by the police in connection with the assault cannot be known, but the likely outcome would have been for him to be interviewed and then bailed pending a full statement being taken from the counsellor.

The young man's acceptance at Rochester

97. When the young man arrived at Rochester on 21 September 2004, he was tired, dishevelled and in obvious need of medical attention. Unfortunately, Rochester is not used to receiving prisoners directly from either the police or the courts, and was not prepared for it. His arrival caused confusion and consternation.
98. There was confusion over who had actually agreed to him being brought to Rochester. The reception SO told the Custody Office AO to tell the police to bring him. He did not have the authority to do so. When the young man arrived, a number of staff of various ranks came to see him. The Deputy Governor spoke to him and agreed that he stay, on compassionate grounds, after the young man had said that he wanted to be at Rochester.
99. The young man had 14 self-inflicted injuries visible on his body, some of which required suturing. He told staff that he would have killed himself if the police had not arrested him. Rochester does not have 24 health care cover. Anyone requiring in-patient care or likely to require medical attention after 9 pm is transferred to HMP Elmley or the local hospital.
100. Despite the presence of a number of senior staff and members of the healthcare team when the young man arrived, some of the standard prison

forms were not completed. These included the First Reception Health Screen and the Cell Sharing Risk Assessment. The result is that I have to rely mainly on post death memories regarding his medical condition. There is no documented record of why he was not put into a shared cell despite being on an open F2052SH.

101. Rochester has not had a self-inflicted death of a prisoner for a number of years and this may have led to a high degree of confidence amongst staff. My investigators found a typical response to be, 'well we must be doing something right.'

The cell

102. With the absence of any documentary evidence to tell me how a decision was made with regard to which cell the young man was to be placed in, it appears that he was put into the only available cell, C4-224 on C wing. C wing has four landings on two spurs each with 16 cells on two floors. The cell was at the far end of one of the first floor landings. Consequently, he was as far from the wing office as it is possible to be on C wing. Rochester's own Suicide Prevention Policy & Strategy Document (SPPSD) states, 'At risk prisoners should be located in cells which facilitate good supervision, i.e. near wing office.'
103. The interior of the cell had numerous ligature points, including several hooked brackets on the wall. The young man was able to remove part of the metal window mechanism, which itself has a finger pull loop to which a ligature could be tied, and used it to remove the wooden window frame surround. He then removed the plastic windowpane. The window has secondary glazing and by sliding it open it is possible to tie a ligature to the aluminium crossbar, which is what he did.
104. The cell in which the young man was placed was unsuitable for a prisoner on an open F2052SH booklet.

F2052SH booklet

105. The purpose of this booklet is to inform staff that there are concerns about a prisoner who may be at risk of self-harm, to record support plans and details of case reviews, and to record observations and interactions with the prisoner. It is a tool intended to help prevent incidents of self-harm or suicide.
106. On his first night in Rochester, observations were increased on the young man from once every 30 minutes to once every 15 minutes after a ligature was found hanging from the window in his cell. The increase was necessary, but prisoners on intermittent supervision should be checked at least five times an hour at irregular intervals. The checks must not be spaced at regular, and therefore predictable, intervals. The OSG noted his observations every 15 minutes, which meant that the timing of his checks was predictable.

107. What has been written in the F2052SH is generally of a good standard. However, I am concerned that two significant interactions with the young man on 22 September were not recorded in the booklet, namely the visit by the nurse and HCW at 10.30 am and the afternoon visit by the Deputy Governor and the PO.
108. There is a need for further staff training in connection with the F2052SH and its use.

F2052SH Case Review

109. The case review was held in an office on C wing after 10.30 am, The notes of the review were written by the nurse at 11.10 am; the time it began is not recorded.
110. The young man presented well at the review; he was animated and took part in the review process. That is at odds with how he was presenting up to that time. The 10 am entry on the booklet reads, 'Remains uncommunicative and will not get up.'
111. The review team was not aware at the time that his girlfriend was a counsellor at Rochester, but they did know that he had assaulted her quite badly and would most likely face charges as a result.
112. The team was aware that during the previous night his watch level had been increased from 30 minutes to every 15 minutes, and that this increase was made after a torn bed sheet ligature had been found attached to the window in his cell. The young man said that he was fed up about the situation with his girlfriend and had made the ligature out of boredom. The team were aware that he was in a single cell, and had self harmed quite badly just prior his arrest by the police the day before.
113. There is no record of the decision making process to explain why at the end of the review his watch was changed from every 15 minutes to hourly. During interviews with the review team, it became clear that staff had an honestly held belief that the young man was not at an imminent risk of committing suicide. I fear that they may have lent too much weight to the way he presented himself during the review. The nurse and HCW had seen him twice within the two hours before the review when he presented in a much less communicative and animated manner.
114. Given the self-harm cuts that the young man had arrived with, the uncertainty of the situation with his girlfriend, the uncertainty over how long he would be held in custody, whether he was facing further charges and his ligature of the previous night, the decision to lower his watch to hourly observations is difficult to justify. I am not clear what further behaviours the young man could have demonstrated to warrant a closer watch, other than an actual suicide attempt.

Response to the discovery of the young man hanging

115. The decision whether a lone officer should enter a prisoner's cell at night is left to his or her judgement and as such I make no comment on the OSG's decision in this case. He correctly communicated the information to the control room staff and, by the time he had returned to the wing office, the other officers had arrived. Cutting the ligature was delayed by the OSG bringing the wrong green box back to the cell. The first aid box did not contain scissors. Rochester's SPPSD in relation to Night Orderly Officers says, 'Ensure all wing patrol staff carry ligature scissors and laederal masks.' None of the officers on duty had a means to cut the ligature but one officer reacted quickly and burnt it through with his lighter.
116. The use of the same green plastic boxes for different emergency situations leads to confusion.
117. Although summoned in good time, the arrival of the ambulance crew was delayed by their inability to find HMYOI Rochester. According to the paramedics, the young man was probably dead when he was first discovered so the delay may not have been significant in this case but could be in the future.

The young man's counsellor

118. The Healthcare Manager, was interviewed in relation to the counsellor's role within Rochester and specifically with regard to any staff concerns about her. He acknowledged the memo submitted in October 2002 which raised concerns about the way a prisoner was behaving at her sessions. That concern was dealt with appropriately.
119. He also agreed that several members of his Healthcare Team had voiced concerns to him regarding the counsellor's sessions. When asked what those concerns had been, he replied, "*Their concerns were about the smartness of the young lads as they came over, the amount of care that they'd put into preparing themselves to actually come to interview. One point, their use of aftershave, if you like, when they came over. The relative position of the counsellor and her client within the room and her sitting posture within the room.*"
120. Apart from passing the counselling room a little more frequently, the healthcare manager did not take any further action regarding the concerns raised by his staff, except to tell them to submit anything objective '*on which he could act*' to him in writing.
121. In interview, he was asked, "In terms of Healthcare staff then having observed her, any more concerns about observations of what she was doing or how she was sitting and that sort of thing?" He replied, "*Those actually did rattle on, yes, they did, reasonably persistently but again, nothing objective that one could get a handle on.*"

122. The counsellor was in a position of trust counselling vulnerable young men like this young man. Whilst staff did not submit their concerns in writing to the healthcare manager, any worries about her professionalism or suitability for her role should have been documented and passed to the prison's senior management for discussion as to what action to take.

Recommendations

National

123. The Prison Service should consider whether to add an attachment sheet to the Licence Revocation Notice for use in exceptional circumstances. This additional page could be used to alert police and prison staff to unusual circumstances, such as when there is no period left to serve in custody.
124. The Prison Service should review its guidance to staff concerning officers entering cells alone at night in emergency situations such as a hanging.
125. The ERRS should review its procedures to ensure that, when a member of the ACR casework team is not in the office, another member of the team follows up their work.

Local

126. Healthcare staff should ensure that the decision making process concerning a patient's care is evidenced in the medical record in accordance with the standards of record keeping required by the Nursing and Midwifery Council.
127. The Governor should remind all staff that any prisoner on an open F2052SH booklet is allocated a cell and observation level commensurate with the risk of self-harm they exhibit.
128. The Governor should remind staff of when and what type of entries to make in the F2052SH booklet.
129. The Governor should review the contents of the Suicide Prevention Policy & Strategy Document, and consider which staff should carry ligature scissors.
130. The Governor should remind staff completing F2052SH case reviews of the need to consider all of the circumstances surrounding a prisoner in crisis and not to place undue weight on any one factor, such as the prisoner himself stating that he is 'okay'.
131. The Governor should arrange for the various emergency boxes in the prison to be more readily identified by using different colours.
132. The Governor or his representative should liaise with the local ambulance headquarters to ensure crews are aware of the location of the prison.
133. The Governor should consider whether there is a case for a disciplinary investigation regarding Healthcare Manager for failing to take proper action

about concerns raised by his staff about the counsellor. (The Governor has responded to this recommendation when commenting on a draft version of this report: *I would not accept this recommendation, as I believe that the proper action, without proof, was taken.*)