PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Thameside in December 2013

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 investigation report into the death of a man who was found hanged in his cell at HMP Thameside on 11 December 2013. He was 60 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the man's clinical care in prison. The prison cooperated fully with this investigation.

The man was released on licence in May 2012 after serving almost 15 years of a twenty two year sentence. He was arrested and charged with further offences on 9 December 2013. His licence was revoked with the potential that he would have to serve the outstanding period of his original sentence plus any new sentence. He was remanded to Thameside on 10 December. His solicitor said that he was very anxious about returning to prison.

The man did not want to share a cell and, to support his case, he told an officer in reception that he was a licence recall from a long sentence and had been used to having his own cell. No one assessed the man to be at risk of suicide and self-harm. The next day, a routine referral to mental health services was made at his own request as he said he suffered from anxiety. A prisoner, who knew the man from outside prison, spoke to him on the morning of 11 December and told the investigator that there was nothing in his demeanour to suggest he was feeling low. The man spent the afternoon and evening of his first day at the prison locked in his cell.

It is a concern that staff at the prison were not aware that the man was recalled, or that this increased his risk of suicide and self-harm. Had they known, they might still reasonably have concluded that he was not at risk of suicide and self-harm, but the fact of his recall, and the possibility that he might have been facing a long time in prison, might have led to a different view of his risk

Although it was too late to save the man, appropriate medical emergency codes were not called when he was found and resuscitation was attempted even though he was clearly dead. Staff guidance is required to address these issues. It is also disappointing that liaison between the prison and the man's family did not go smoothly and that the police broke the news of his death to them, rather than someone in person from the prison.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **August 2014**

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SUMMARY

1. In 1997, the man was sentenced to a total of 35 years in prison for robbery and firearms offences. In 2000, his sentence was reduced on appeal to 22 years. He was released on licence under the terms of the discretionary conditional release scheme in May 2012.

2. On 9 December 2013, the man was arrested and charged with attempted robbery and possession of a bladed weapon. The police informed his local probation team and, on 10 December, his licence was revoked and the recall process started. Under the terms of the discretionary conditional release scheme, the man was liable to be required to serve all or part of the remaining period of his original sentence in addition to any new sentence imposed for the charges brought on 9 December.

3. The man appeared at Thames Magistrates' Court on 10 December and was remanded into custody. He was taken to HMP Thameside the same evening. The man told a member of staff in reception that he had been on licence from a long sentence and wanted a single cell. He became agitated when told that all cells at Thameside were shared, but otherwise the man gave no cause for concern and was not assessed as being in need of special monitoring. Most staff who came into contact with the man were unaware he was subject to licence recall and those who assessed his risk of suicide and self-harm did not ask him about this.

4. Staff on the first night centre agreed the man could have a cell on his own as he was so insistent. The man spoke to another prisoner, who he knew, during the morning of 11 December. The other prisoner said that the man was annoyed about the charges he was facing, but did not seem low or unable to cope. He said the man seemed exactly how he had been when he had last seen him outside prison.

5. The man attended the morning induction presentation on 11 December and had a secondary health screen at 10.30am. Apart from leaving his cell to collect his lunch and dinner, the man spent the rest of the day locked in his cell. He used the intercom system in his cell to contact staff three times between 10.50am and 2.40pm, but there is no record of the reasons. He was seen alive at afternoon roll count at 5.50pm.

6. At 10.55pm, during the evening roll count, the man was discovered hanging from the bunk beds in his cell. Although there was some initial confusion about medical emergency codes, staff promptly went into his cell to assist him and nurses arrived within seconds. It was evident that the man had died but cardiopulmonary resuscitation (CPR) was performed despite the presence of rigor mortis. Paramedics pronounced the man dead at 11.16pm. The police, rather than the prison staff, informed his family of his death.

7. We make recommendations about raising staff awareness of factors that indicate a raised risk of suicide and self-harm, emergency codes, the circumstances in which resuscitation is inappropriate and family liaison.

THE INVESTIGATION PROCESS

8. The investigator issued notices about the investigation to staff and prisoners at HMP Thameside inviting anyone with information to contact her. No one came forward.

9. The investigator visited Thameside on 17 December 2013 and met the then Director and his senior management team. The investigator saw the man's cell and spoke to a prisoner who knew the man. She collected copies of the man's prison record and other relevant paperwork. The investigator interviewed staff at Thameside on 26 February and 6 March 2014. She spoke to two other members of staff by telephone. She watched the CCTV recording from 11 December 2013. The investigator gave feedback to the prison on emerging issues after the interviews.

10. The investigator spoke to the man's offender manager (probation officer), the senior probation officer and the senior custody officer at Thames Magistrates' Court. She also spoke to the police investigator, the man's solicitor and a member of staff in the public protection case management section in the National Offender Management Service (NOMS).

11. NHS England (London Region) commissioned a clinical reviewer to review the man's clinical care at Thameside. The investigator and clinical reviewer interviewed two members of staff together.

12. One of our family liaison officers, informed the man's wife about the investigation. The family liaison officer and the investigator met the man's wife and sister who asked for a detailed account of the man's time in Thameside. The man's wife was upset that she had been told of her husband's death by the police at 5.30am the following morning. She said the Director had promised her that she could see the man's cell before his possessions had been cleared from it. However, when she visited the prison in January the cell had been cleaned and emptied. The man's wife and sister asked if staff were aware that the man was a licence recall prisoner as they believed this was a significant risk factor. They thought that prison staff should have been alerted to this by the court or probation service. They asked for more information about how the man was able to hang himself in the way described to them and whether he had received his prescribed medication in prison.

HMP THAMESIDE

13. HMP Thameside is a local category B prison that can hold up to 900 men. It opened on 27 March 2012 and is privately run by Serco. All standard cells contain two bunks, an integrated toilet and shower, a telephone and a computer for communication within the prison. Prisoners use the computer to book visits, request out-patient appointments with healthcare staff, order from the prison shop and choose their meal options. Health Services are contracted to Care UK and there is 24 hour nursing provision.

14. The induction and first night centre is on the upper floors of A wing (A3 and A4). All new receptions are taken to A wing for induction before being moved to other wings.

Her Majesty's Inspectorate of Prisons

15. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Thameside in January 2013. Inspectors found that reception into custody was reasonable and prisoners felt safe. Staff were welcoming but the process sometimes took too long. Peer mentors and Listeners (prisoners trained by the Samaritans to offer confidential peer support) were used well in reception. Inspectors found first night accommodation was clean and well prepared and arrangements were generally sound. New arrivals had a private interview with staff, but some staff did not fully understand vulnerability or first night risk factors. Inspectors recommended that all staff completing cell sharing risk assessments and first night risk assessments should be properly trained and the quality of assessments improved.

Independent Monitoring Board

16. Every prison in England and Wales has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. The first report from the Thameside IMB covers the period between March 2012 and June 2013. The IMB considered that care was taken to identify prisoners at risk of suicide and self-harm and ACCT documents were implemented conscientiously. Staff received regular ACCT refresher training. (ACCT is the Prison Service suicide and self-harm prevention procedure.)

Previous deaths at Thameside

17. The man was the second person to die at Thameside and the first self-inflicted death. In our investigation into the previous death we made a recommendation about the use of an emergency code system and putting in place a protocol with the London Ambulance Service.

Discretionary conditional release and licence recall

18. Prisoners sentenced to four years or more on or after 1 October 1992 and before 4 April 2005 are subject to the discretionary conditional release

scheme. They are eligible to apply for release by the Parole Board at the half way point of their sentence. If the Parole Board does not direct their release they are automatically released on conditional licence at the two thirds point of their sentence (known as their non-parole release date or NPD). The licence period expires at the three quarters point of their sentence. If a prisoner breaches a condition of their licence before their licence expiry date they can be recalled to prison until the Parole Board directs their release. Prisoners who commit a further imprisonable offence before their sentence expiry date risk being returned to prison to serve all or part of the outstanding period of the original sentence as well as any new sentence imposed.

The licence recall process

19. The decision to apply for a person on licence to be recalled to prison is taken by their local probation office. The decision is based on whether the person's risk of re-offending can be managed in the community. The offender manager (probation officer) completes a recall report which is countersigned by a senior probation officer and an acting chief officer. This is sent electronically to the Public Protection Casework Section (PPCS) in the National Offender Management Service (NOMS) who decide whether to revoke the person's licence. PPCS check NOMIS (the electronic database of prisoners) to see if the person is in custody. Notification of licence revocation is sent electronically to the local police, New Scotland Yard, the local probation office and the prison. The email to the prison goes to the custody department inbox. A recall dossier is sent to the prison within 24 hours. The prison must ensure the recall dossier is disclosed to the prisoner immediately. In the man's case, his licence was revoked by PPCS on 11 December and an email sent to the custody inbox the same day. This was seen by the custody clerk and an alert added to the man's PNOMIS record also on 11 December. The recall dossier was sent to Thameside on 12 December after the man had died.

KEY EVENTS

20. In September 1997, the man was sentenced to thirty five years in prison for robbery, possession of a firearm with intent and grievous bodily harm. In May 2000, his sentence was reduced on appeal to 22 years. The man was released on licence on 11 May 2012 under the discretionary conditional release scheme at the two thirds point of his sentence. The man had been a category A prisoner and had served his sentence in a high security prison.

21. On 9 December 2013, the man was arrested and taken to Bethnal Green Police Station. According to the police record of custody, the man said he felt fine, had no medical problems, no mental health problems and had not tried to harm himself before. He reported that he had a graze to his right wrist. The man saw a police medical officer the same evening as he had not taken his prescribed medication that day. The man told the police medical officer that he was prescribed anti-depressants and medication to help him sleep. He said he sometimes took painkillers for gallbladder problems. The man was described as alert, oriented, coherent and co-operative, but refused to take any medication or let the doctor examine the graze on his wrist. The man's wife told the investigator that she had taken her husband's medication to him at the police station.

22. The man's solicitor, saw him at the police station. She told the investigator that he was very anxious about what was going to happen to him. The man told her that the doctor had given him something for his anxiety (although he had refused medication.)

23. The next day, the man was charged with assault with intent to commit robbery and possession of a knife blade or sharp pointed article in a public place. He was taken to Thames Magistrates' Court. A Police Sergeant completed the man's person escort record (PER – the form that accompanies a person between police, court and prison and lists risk factors) and noted risk factors for violence, heroin use and attempted murder with a hand gun. In the health risk section, it was noted the man had gall bladder problems and was on anti-depressants. The man arrived at Thames Magistrates' Court at 9.26am.

24. The solicitor saw the man at court at about 10.30am. She said the man had soiled himself as he had not been able to get to the toilet fast enough. He had been given a clean pair of trousers that were much too small for him. She raised this with a Senior Custody Officer who agreed that he could have a clean pair brought in. The solicitor contacted the man's wife who brought some jogging bottoms for him. The Senior Custody Officer said the man had appeared calm and was pleased to receive the jogging bottoms.

25. The solicitor said the man was very anxious when she spoke to him and asked her repeatedly whether his licence would be revoked and he would be recalled to prison. The solicitor said that a member of court probation staff had told her that the man's licence was being revoked, so she did not make an application for bail. She said the man had asked if he could go straight to HMP Belmarsh from court because he was used to high security prisons. She

discussed this with the Senior Custody Officer who explained that everyone from the court went to HMP Thameside.

26. The man was remanded into custody and arrived at HMP Thameside, at about 7.45pm. The man's details were added to the prison's custodial management system (CMS), P-NOMIS (the electronic record system) and his paper core prison record. His legal status was recorded on CMS and in his core record as 'on remand' and as 'unsentenced' on P-NOMIS. The P-NOMIS case notes describe him as an 'unconvicted remand prisoner'.

27. Prison Custody Officer (PCO) completed a cell sharing risk assessment (CSRA – an assessment of whether a prisoner poses a risk to others if sharing a cell). The PCO said the man appeared polite and calm, but became quite agitated when she said he would have to share a cell. She said he told her that he was a licence recall from a long sentence in a high security prison and was used to having a cell of his own. The PCO said she explained that he did not fit the criteria for being in a single cell. The man said he would rather go to the prison's segregation unit than share a cell. The PCO copied the risk factors from the man's PER and reported what he said in the comments section of the cell sharing risk assessment. She marked the top of the form to show he was a remand prisoner. The PCO said she did not mark the man as a licence recall because he was held on a remand warrant.

28. The PCO said she had been worried that the man might refuse to go to the first night centre. After the interview, while the man was waiting to have his reception health screen, she spoke to the reception manager, and the nurses on duty. She said she told them what he had said about being a licence recall from a long sentence and used to having a single cell and that he had threatened to go to the segregation unit rather than share. The PCO said it was a busy night and there were three nurses on duty. She could not remember which one she spoke to.

29. A health care assistant interviewed the man for his first reception health screen at 8.40pm. The healthcare assistant told the investigator that she had a copy of the man's PER and the cell sharing risk assessment completed by the PCO. When she put the man's details in to the computer she was also able to see his previous prison medical record on SystmOne. The healthcare assistant described the man as calm and relaxed. She said he laughed with her during the interview and appeared settled. He told her he was remanded on charges of robbery and had been in prison before. She said that she did not know he had been on licence from a previous sentence. The man told her that he suffered from anxiety and depression and was prescribed sertraline (an anti-depressant) by his GP. He also said he had arthritis and took painkillers for gallbladder problems. The healthcare assistant referred the man to the reception GP to continue his prescription for sertraline. She completed her part of the cell sharing risk assessment to indicate that there were no current health reasons to prevent the man from sharing a cell.

30. Part of the reception health screen involves a risk assessment consisting of eight factors: history of self-harm, previous management on ACCT, history of

mental illness or engagement with mental health services, history of substance misuse, recent change in family relationships, recent change in circumstances (long prison sentence, unexpected remand), licence recall and persistent thoughts of self-harm and/or stated intentions to act on those thoughts currently or over the previous four weeks. Each factor has a score and the total score directs the next response. A score of three and over triggers a referral for a mental health assessment. A score of five and over triggers urgent referral to the mental health team, consideration of admission to the prison inpatient unit and consideration of opening an ACCT (suicide and self-harm prevention procedures). A score of six and over triggers admission to the inpatient unit and the opening of an ACCT. Using the information available to her, the healthcare assistant gave the man a score of one – because he had told her of his past use of heroin.

31. The man saw a doctor at 9.30pm and told him he felt anxious and depressed, but had no thoughts of self-harm. He said he was eating and drinking well, but sleeping poorly. The doctor prescribed sertraline at the man's usual dose and also prescribed promethazine hydrochloride (an anti-histamine used to help sleep). He noted the medical record in capital letters, "please provide him with a single cell if available".

32. The man then spoke to two peer mentors (prisoners who work in reception and the first night centre who help new prisoners settle in and complete some of the induction documents with them). After the man's death, both men met the man's wife when she visited the prison. They told her that the man had not given them any cause for concern that evening. The man was then offered a reception telephone call. The prison log shows he tried to call his wife, but the call failed to connect.

33. The man was taken to the induction and first night centre on A wing landings 3 and 4 known as A uppers. The PCO conducted the man's first night interview at one of the tables on A3 landing, which did not provide much privacy from other prisoners and staff. The PCO told the investigator that the purpose of the first night interview is to complete a form with set questions on it and also to chat and try to establish a relationship with the prisoner. The officer checks whether prisoners have completed their reception health screen, have had a reception phone call, have adequate clothing, tobacco (if they smoke) and their ID card. The other questions relate to nationality, first language, faith or religion, literacy and numeracy, disability, history of violence, racism, homophobia and gang membership.

34. Apart from the form they are required to complete, the first night officer has a copy of the prisoner's cell sharing risk assessment and a form completed by the nurse or healthcare assistant in reception in front of them, which indicates whether any issues of self-harm have been identified, if there are any immediate health concerns and whether the prisoner needs a detoxification programme. The PCO said he did not know why the man was in prison or whether he had been in prison before. He said that he tried to engage the man in conversation, but he was not very chatty. He maintained good eye

contact, but said he just wanted to go to his cell and go to sleep. The PCO said the man did not seem in any distress.

35. Another PCO who was also on duty on A wing uppers said there was no supervising officer on duty that night and so she was in the supervisor's office updating the records as new receptions were allocated cells. She said a male colleague asked her to come down to speak to the man who was refusing to share a cell, and the colleague thought the man might listen to her. The PCO said the man remained adamant he did not want to share a cell. She told him he could go into cell A3/21 on his own, but it did not have a working television. She said the man said he did not mind as long as he was on his own. The PCO said she had not wanted to cause the man unnecessary anxiety on his first night and thought it best to put him in a cell on his own and wait for a supervising officer to review her decision in the morning.

36. The next morning at about 9.00am, the man attended a presentation about the regime and facilities at Thameside in the induction room. A prison peer mentor attended the induction and told the investigator he had met the man outside prison in 2012 and recognised him when he saw him at the presentation. Afterwards he spoke to the prisoner who told him that he could not believe he was back in prison on what he described as a "bullshit charge". He said the man appeared stunned about what had happened and "pissed off" about the charges he would be facing. He told the prisoner that his solicitor had warned him he might get a life sentence if he was found guilty.

37. The prisoner said the man's main concern appeared to be that he wanted a single cell and was worried he would be asked to share. He told the prisoner that his cell computer did not appear to be working and the prisoner went back to his cell with him to show him how it worked. The prisoner told him he would come back over in the afternoon and bring the man some toiletries, but in the event was unable to do so because he was at a meeting that over ran. He said the man was exactly how he remembered him from outside prison and did not seem anxious or low in mood.

38. The healthcare assistant completed the man's secondary health screen at 10.33am in the treatment room on A3 landing. The secondary health screen concentrates on the prisoner's general health. The man said he was up to date with all vaccines and immunisations and did not want a sexual health screening and hepatitis B vaccination. The healthcare assistant booked him an appointment with a triage nurse because his blood pressure was raised. The man asked to see to the mental health team because he suffered from anxiety and panic attacks and the healthcare assistant put him on the waiting list. She said the man told her that he was anxious about sharing a cell but otherwise said the man was cheerful, communicative and cooperative and was no different to when she had seen him the night before.

39. The PCO completed the second-day check of the man's cell sharing risk assessment which involves checking the prisoner's Police National Computer (PNC) record in the prison security department. The man was still regarded as suitable to share a cell. The PCO said she later spoke to the man in

passing when he collected his lunch. She asked him if he was okay and whether he had changed his mind about sharing a cell and perhaps moving to one with a working TV. The man told her he was happy where he was. She said he seemed calm and happy to chat.

40. Another PCO who was on duty on A3 on 11 December, told the investigator that, at the time, prisoners stayed in their cells during the afternoon on the first day of their induction and did not come out unless they had an appointment with the Turning Point worker (a charity supporting people with substance and mental health issues) and to collect their dinner.

41. At some point on 11 December the custody clerk, added an alert to the man's NOMIS record in response to an email to the custody inbox from Public Protection Casework Section (PPCS) to show that he was subject to licence recall. The entry is not timed. The cell intercom log shows that the man used the intercom to contact staff at 10.50am, 11.16am and 2.50pm. The log shows that the calls were answered quickly, but there is no record of what he wanted.

42. CCTV shows that the man left his cell at 4.51pm carrying a blue plate. A minute later he returned and came out immediately with the same plate, but also now carrying his prison ID card. At 4.57pm, he returned to his cell with a plate of food. A minute later, a PCO looked into the cell and closed the door. The man did not come out of his cell again. At 5.52pm, the PCO checked the cell for a roll count. This is the last time the man was seen alive. There was no evening association that night. CCTV shows that no one went to his cell door during the evening. At about 10.30pm, new receptions arrived on the wing and were interviewed before being put in their cells.

43. CCTV shows that another PCO the night patrol officer on A wing checked the man's cell at 10.55pm as part of the night roll check. The PCO said he looked through the observation panel and saw the man sitting on the floor by the bunk beds with both hands behind his back. He then noticed he had something tied around his neck and told the investigator that he radioed to call for "immediate medical response code red". The PCO unlocked the man's cell and went in. He left the cell briefly to take his cut down tool from his belt and went back in. CCTV shows that 26 seconds elapsed between the PCO looking through the cell door and going in to the cell with his cut down tool.

44. The PCO said the man was sitting on the floor with his legs out in front of him. His hands were behind his back and were not tied. The PCO said the man had a ligature which looked like cord or lace wrapped around his neck. He was not sure what it was made from, but it was not the cable from the TV. The ligature was tied to the base of the cell TV which had been placed on the top bunk with two mattresses on top of it. The PCO cut the ligature from the TV and tried to put the man on his back on the floor.

45. Another PCO said he was on A4 landing when he heard the PCO call for immediate medical response. When he arrived he saw the PCO going into the cell with his cut down tool. The other PCO said the man was in a sitting

position with a ligature tied very tightly around his neck. A third PCO was in the supervisor's office on A4 when she heard the radio call. She did not hear exactly what the PCO had said, but responded to the urgent tone in his voice. She arrived after the ligature had been cut from the TV and used her cut down tool to remove the remaining section from around the man's neck. She was about to radio a code blue but, as she did so, two nurses arrived. The PCO described the man as stiff and his arms were discoloured. The third PCO said the man was cold and stiff.

46. A nurse said she had been in A3 treatment room when she heard the PCO's radio message. She said she did not understand what he was saying as he was speaking very fast and did not hear an emergency code. She a second nurse went immediately to the man's cell. She took a small red bag which was used for treating minor injuries because she was not sure what the nature of the emergency was. As soon as they got to the cell, the nurse said she realised it was a code blue emergency. She started chest compressions (cardiopulmonary resuscitation – CPR) while the second nurse went to get an emergency bag and oxygen. They gave the man oxygen and attached him to a defibrillator. The defibrillator was unable to detect a shockable rhythm.

47. The Supervising Officer was in the centre office on level one when she heard the PCO's call for immediate medical assistance. She ran up two flights of stairs to A3 landing. As she got to the landing she saw the nurse running towards her. CCTV shows the Supervising Officer arrive on A3 at 10.57pm. She said she saw the nurse doing chest compressions and immediately radioed a code blue, which indicates that someone is not breathing or has collapsed. She said that the PCO had only called for immediate medical assistance, whereas a code blue would prompt the communications officer to call an ambulance. The Supervising Officer said the man was lying on his back on the floor. She could see a mark around his neck and said his fingers were clenched into fists.

48. The London Ambulance Service patient report form shows that the prison called an ambulance at 10.57pm and it was dispatched at 10.59pm. The ambulance arrived at the prison at 11.04pm and CCTV shows that the paramedics went into the man's cell at 11.14pm. The paramedics asked prison staff to stop CPR because it was apparent that the man was dead and rigor mortis and post-mortem staining were present.

49. The prison followed their death in custody contingency plans. The police and Coroner were informed. Senior managers attended the prison. At 1.30am, the Director led a hot debrief for all the staff involved in the emergency. The care team and chaplaincy attended and spoke to staff. Arrangements were made for staff to go home and taxis were provided for those who did not feel able to drive. Prisoners on open ACCTs were reviewed and checked in case they had been affected by the man's death.

Family liaison

50. The duty manager told the investigator that the police who came to the prison told her that because he had recently been in police custody they would break the news of his death to the man's wife. The director at Thameside, told the investigator that the police had said that they regarded the man's death as a death in police custody because he had been held at a police station within the previous 48 hours. The director said he knew it was expected that prison staff should break the news but, as it was night time and the police had officers available, he agreed that it was sensible for the police to break the news. The director gave the police his contact details to pass to the family.

51. The man's wife said that two officers from Islington police visited her at 5.30am on 12 December and told her that her husband had died. At her request the officers drove her to her sister-in-law's house. The man's wife telephoned the director and told him she was on the way to the prison with her sister-in-law and her husband. The director met them in the board room, but the man's family were not able to see the cell because it was still sealed by the police. The director promised them that they could see it as soon as it was released. The man's wife said he had also promised them that they could talk to the prisoners in adjacent cells and meet the staff involved in the emergency response. The man's wife said that she had told the director she wanted to see the cell exactly as her husband had left it and she left on the understanding that this would be possible. She believed that the director would contact her when this could be done.

52. The director wrote to the man's wife on 16 December. In his letter he invited her to visit the prison when the man's cell had been "released by the Ombudsman and Coroner's Office" and meet some of his friends. The investigator visited Thameside on 17 December and saw the man's cell. The man's property, his last meal and resuscitation equipment were still in the cell. The police had removed the television and the ligature but the mattresses were still on the upper bunk. According to the prison family liaison log, the prison family liaison officer telephoned the man's brother-in-law on 24 December. He said he thought that the man's body would be released by the Coroner in early January and that the man's cell would be released then too. His family visited the prison again on 7 January. They walked through the reception process and met the peer mentors who spoke to the man on 10 December. They also spoke to two prisoners including the prisoner who had known the man previously. The man's wife said that she saw a cell, but did not think it was the man's although it was. The cell had been cleaned and none of his personal effects were in it. She was upset that it had not been left as it was as she believed had been promised. The investigator subsequently showed the man's wife photographs of his cell taken just after he had been found.

53. The prison returned the man's property and offered appropriate financial assistance with his funeral in accordance with national prison guidance.

Further action taken by the prison

54. Since the man's death, additional medical emergency bags have been put in on the upper landings of each house block. The head of security has instructed reception staff to ask all new receptions whether they are subject to licence recall and, if so, when their sentence expires.

Post-mortem

55. We have not received a post-mortem report at the time of writing. The Detective Sergeant of Greenwich CID told the investigator that the preliminary cause of death was suspension.

ISSUES

Assessment of risk

56. The man was a 60 year old man potentially facing most of the rest of his life in prison. It was only 18 months since he had been released after spending almost 15 years in prison. He had seven years of a 22 year sentence left to serve plus any additional time if he was convicted of the offence he was arrested for on 9 December. Prison Service Instruction (PSI) 64/2011 gives guidance on identifying prisoners who may be at risk of suicide or self-harm. Licence recall is listed as a known risk factor.

57. The man's local probation office sent a recall report to Public Protection Casework Section (PPCS) on 10 December. His licence was revoked on 11 December and email notification sent to police, probation and Thameside's custody office. The recall dossier was sent to the prison on 12 December, the day after he had died. Because licence recall is a probation service process, the court custody staff at Thames Magistrates' Court were unaware that he was subject to licence recall. The man was held on a remand warrant, his PER described him as on remand and he was treated as a remand prisoner at Thameside. (Once a prisoner is known to have been recalled from licence they are treated as sentenced prisoners.)

58. The PCO told the investigator that the man had said during his interview for his risk of sharing a cell that he was licence recall from a long sentence. The PCO said she was not aware that licence recall was a risk factor for suicide or self-harm and her consideration was about whether he should be allocated a single cell. She said she told other staff in reception, including healthcare staff, that the man had been recalled from a long sentence because she was worried that the man would refuse to go to a normal wing if he had to share. None of the other staff we interviewed said that they had known that the man had had his licence revoked.

59. The healthcare assistant said that the man told her that he had been in prison before, but described himself as on remand. Questions about licence recall and change in circumstance, including receiving a long sentence, appear on the list of questions in the risk assessment in the reception health screen at Thameside. Using the risk assessment scores, the healthcare assistant scored the man's risk as one. The man told her he suffered from depression and was prescribed sertraline, which should have added a point for history of mental illness. Had she known he was a licence recall and returning to prison for a significant time, his score would have been five, which meant he would have been referred for an urgent mental health assessment to take place within 48 hours. The healthcare assistant referred the man for a mental health assessment at his second health screen at his own request. Even if he had been referred urgently on 10 December, an assessment might not have taken place before he died. However, had the healthcare assistant, or any other staff, been aware that the man's recall to prison meant that he was facing a long period in custody, they might have taken a different view of his risk.

60. Most staff who spoke to the man were not aware that he was subject to licence recall and those that were did not know that it was a risk factor associated with suicide or self-harm. Since the man's death, the prison have instructed first night staff to ask questions about licence recall as part of the reception process. We welcome this change, and we accept that it will not always be immediately apparent to reception staff when a prisoner has been recalled. However, it is important that reception staff should have a good understanding of the risk factors for suicide and self-harm when assessing new prisoners. We make the following recommendation:

The Director should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:

- **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**
- **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and other sources.**

The emergency response

61. Prison Service Instruction (PSI) 03/2013 requires all prisons to operate an emergency code system to effectively communicate the nature of an emergency and ensure there is no delay in calling an ambulance. Thameside adopted such a policy as a result of a recommendation we made following their previous death in custody, but it does not appear that this is embedded. We note that the PCO entered the man's cell quickly, that the emergency response nurse arrived at the cell almost immediately and the fact that the man was already dead. However, the PCO did not use the appropriate code system to alert colleagues to the nature of the emergency. As a result, the nurses did not immediately bring the emergency bag and oxygen and an ambulance was not called until The Supervising Officer radioed a code blue two minutes later.

62. While the delay was relatively short and did not alter the outcome for the man, in cases of hanging every second can be crucial to the success or failure of resuscitation. The correct use of emergency codes would have clarified the emergency, ensured an ambulance was called without delay and ensured that staff brought the most appropriate medical equipment immediately. We make the following recommendation:

The Director should ensure that all prison staff are made aware of and understand PSI 03/2013 the local emergency procedures and their responsibilities during medical emergencies including the use of appropriate emergency codes.

63. Thameside's death in custody contingency plans direct the emergency response nurse (Hotel 1) to "administer and continue resuscitation until the prisoner is pronounced dead, unless rigor mortis of the limbs has clearly set in." This is in line with the European Resuscitation Guidelines for Resuscitation 2010 which state, "resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile." The guidelines define examples of futility as rigor mortis and the presence of post-mortem staining. The clinical reviewer, concludes that the attempted resuscitation of the man was inappropriate. We agree that administering resuscitation in such circumstances is distressing for all those involved. All staff need to be aware of the guidance in the local policy. We make the following recommendation:

The Director and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.

Family Liaison

64. Prison Service Instruction 64/2011 gives guidance to prisons on contacting families after a death in custody. It says that, wherever possible, the FLO and another member of staff must visit the next of kin or nominated person to break the news of the death. The duty manager told the investigator that the police said that the man's death counted as a death in police custody because he had been held at a police station within the previous 48 hours. They said they would take responsibility for telling the man's wife. The director told the investigator this is what happened. He said that he knew it was Prison Service Guidance that prison staff should break the news but, as the police had officers available and his staff were still in bed, he agreed that the police should break the news.

65. It is unfortunate that the police muddied the waters in this case. The man did not fit the criteria of a death in police custody, which is within 24 hours not 48 hours of release from a police station. Regardless, the director knew that it was also his responsibility to break the news of the man's death. The man's wife lives in North London, not far from HMP Thameside. PSI 64/2011 also stresses that time is of the essence in breaking the news of a death in order to ensure that the next of kin do not find out by other means. In the event, it was not the police officers who had attended the prison who broke the news of the man's death to his wife, but officers from a local police station at 5.30am the next morning, six hours after the man had been pronounced dead.

66. We consider that the prison should have taken responsibility for telling the man's wife he had died and that this should have been done sooner. At the very least they should have ascertained when the police intended to do this. We make the following recommendation:

The Director should ensure that where possible someone from the prison breaks the news of a death at the prison to families in person and as soon as possible.

67. It is regrettable to hear that the man's wife had been told that she would be able to see her husband's cell before it was cleared of his possessions and cleaned and yet she did not. It is not clear why there was a delay in the man's family visiting the cell which the investigator was able to see on 17 December after it had been released by the police. The director's letter of condolence of 16 December mentions that the cell needed to be released by the Ombudsman and the Coroner. The family liaison log refers on 24 December to the expectation that the Coroner would release the cell in early January. Neither we nor the Coroner release cells, which is solely a matter for the police.

The first day regime on the induction and first night centre

68. The man spent a considerable amount of time at Thameside alone in his cell. The TV was broken and as a new arrival he would have had few possessions and distractions. This was a long time for him to brood on his situation. Since the man's death, we have been told that the regime for new arrivals has been changed so that prisoners have their education and gym induction on their first afternoon. We therefore make no recommendation.

RECOMMENDATIONS

1. The Director should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:

    - Have a clear understanding of responsibilities and the need to share all relevant information about risk.
    - Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and other sources.

2. The Director should ensure that all prison staff are made aware of and understand PSI 03/2013 the local emergency procedures and their responsibilities during medical emergencies including the use of appropriate emergency codes.

3. The Director and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.

4. The Director should ensure that where possible someone from the prison breaks the news of a death at the prison to families in person and as soon as possible

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Director should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff: * Have a clear understanding of responsibilities and the need to share all relevant information about risk. * Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and other sources.	Accepted	• All First Night Centre Staff, Reception Staff and Healthcare Staff will be subject to awareness training on the signs of self-harm/self inflicted deaths including information from suicide and self harm warning forms, PERS and other sources. • In addition to the guidance in PSI 64/2011 on identifying and managing risk, documentation will be produced locally so that any new reception will have a clear trail of notes identifying any known triggers, or any new concerns. This will include all identified risks from the Safer custody PSI. The initial entries will be made reception, followed by the healthcare stationed in reception, and then handed over to the first night centre. The document will be signed by each department including the final handover to the FNC	August 2014	

			officer. The document will be accompanied by the CSRA which will also highlight any concerns of risk. The information used for the document will come from, court documentation, PERs, verbal handover from the escort staff, and any first hand observations. • Included in the documentation will be a separate check and signature for the Reception Unit Manager and the FNC Unit Manager.		
2	The Director should ensure that all prison staff are made aware of and understand PSI 03/2013 the local emergency procedures and their responsibilities during medical emergencies including the use of appropriate emergency codes.	Accepted	A Notice to Staff has been issued to all staff. This will be taken from PSI 03/2013 and will include the local emergency procedures and their responsibilities during medical emergencies including the use of appropriate emergency codes. Adherence to this will be monitored via regular briefings which will be documented and evidenced on the Daily Staff Briefing Sheets, Safer Custody Meetings, evidenced by the minutes.	30/06/14	
3	The Director and Head of Healthcare should ensure	Accepted	The guidance, in line with the	31/07/14	

	that staff are given guidance about the circumstances in which resuscitation is inappropriate.		European Resuscitation Guidelines for Resuscitation 2010, will be produced in conjunction with head of healthcare and disseminated to all staff. Separate guidance will be offered for First on Scene (Operational Staff) and medical staff. This will be issued initially as a notice to staff for all staff and will be re inforced through staff briefings and Safer Custody meeting and will be evidenced in the minutes.		
4	The Director should ensure that where possible someone from the prison breaks the news of a death at the prison to families in person and as soon as possible	Accepted	The prison Family Liaison Officer will wherever possible, break the news of a death at the prison to the deceased's family.	31/07/14	