

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Joseph McCauley a prisoner at HMP Manchester on 30 March 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Joseph McCauley was found hanged in his cell at HMP Manchester on 30 March 2016. He was 23 years old. I offer my condolences to Mr McCauley's family and friends.

Mr McCauley had been in prison before but had arrived at Manchester only nine days earlier. There was very little to indicate that Mr McCauley was at risk of suicide or self-harm or that he needed increased monitoring. I am satisfied that staff at the prison could not have foreseen or prevented his death.

Although it did not affect the outcome for Mr McCauley, there were some deficiencies with emergency procedures which the prison will need to rectify.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

February 2017

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Summary

Events

1. On 21 March 2016, Mr Joseph McCauley was charged with a serious sexual offence and remanded into custody at HMP Manchester. Mr McCauley had served previous custodial sentences and had been released on licence from his most recent sentence on 11 June 2015. He had no record of mental illness, suicide attempts, self-harm, drug or alcohol abuse.
2. Healthcare staff at Manchester identified that Mr McCauley had no physical or mental health problems and was not prescribed any medication. No one considered he was at risk of suicide.
3. On 30 March, at 5.39am, an officer found Mr McCauley hanged in his cell and raised the alarm. Officers and nurses did not attempt to resuscitate Mr McCauley as it was clear he had been dead for some time. At 6.02am, the paramedics pronounced Mr McCauley dead. Mr McCauley had left a suicide note addressed to his family.

Findings

4. Mr McCauley gave no indication that he was at risk of suicide and we do not consider that prison staff could have predicted or prevented his actions.
5. Although staff responded to the incident quickly, no one used the required medical emergency code. This meant there was some delay in calling and despatching an ambulance. While this did not affect the outcome for Mr McCauley, such a delay could be critical in other circumstances. A recently issued Manchester staff instruction about handling medical emergencies did not reflect the requirement of the national instruction to call an ambulance immediately.

Recommendations

- The Governor should ensure that the prison's local emergency protocol meets the requirements of PSI 3/2013, *Medical Emergency Response Codes*, and that the control room calls an ambulance immediately a medical emergency code is called, without waiting for further confirmation.

The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Manchester informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
7. The investigator visited Manchester on 4 April. He obtained copies of relevant extracts from Mr McCauley's prison and medical records.
8. NHS England commissioned a clinical reviewer to review Mr McCauley's clinical care at the prison.
9. The investigator interviewed eight members of staff and three prisoners at Manchester in April and May, and one prisoner at HMP Risley in April.
10. We informed HM Coroner for Manchester of the investigation and he gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
11. One of the Ombudsman's family liaison officers contacted Mr McCauley's family to ask whether they had any matters they wanted the investigation to consider. Mr McCauley's family wanted to know whether Mr McCauley had been bullied or assaulted and whether he was placed under protection. Mr McCauley's family received a copy of the initial report. The solicitor representing Mr McCauley's family wrote to us pointing out an actual inaccuracy. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Manchester

12. HMP Manchester operates as both a high security prison and as a local prison serving the courts of the Greater Manchester area. It can hold over 1,200 men. Manchester Mental Health and Social Care Trust provides 24-hour nursing care and the healthcare centre includes an inpatient unit

HM Inspectorate of Prisons

13. The most recent inspection of HMP Manchester was conducted in November 2014. Inspectors reported good relationships between staff and prisoners. Inspectors found that Manchester focused on preventing self-inflicted deaths and learned lessons from each incident. The levels of self-harm were comparatively low and care for those at risk was good. Vulnerable prisoners generally felt safe, however support for victims of violent incidents needed to be improved. Health provision was generally good. Inspectors noted that there was a high incidence of mental health and substance misuse problems.

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 29 February 2016, the IMB reported that the health and welfare of prisoners was given a high priority. The IMB commented that the main challenges for the prison have been the availability of mobile phones, drugs and offensive weapons.

Previous deaths at HMP Manchester

15. Mr McCauley's death was the second self-inflicted death at Manchester since January 2016. There were similarities between this death and that of Mr McCauley in relation to the emergency response. After Mr McCauley's death, there have been two further deaths but these were from natural causes.

Key Events

16. On Monday 21 March 2016, Mr McCauley was charged with a serious sexual offence and remanded into custody at HMP Manchester. He was due to appear at Crown Court on 18 April 2016. Mr McCauley had been in prison before and had been released on licence from his most recent sentence at HMP Haverigg on 11 June 2015. He had no history of self-harm or suicide, and was not prescribed any medication.
17. On arrival at Manchester, Mr McCauley's escort record, completed at court, noted that he had been charged with a serious sexual offence, but did not identify any concerns about suicide or self-harm. An officer completed reception documentation with Mr McCauley. She recorded that Mr McCauley had no thoughts of suicide or self-harm. She did not consider that he was at risk of suicide. Due to the nature of his offence she offered Mr McCauley vulnerable prisoner protection, but he declined.
18. An officer completed the cell sharing risk assessment and recorded that Mr McCauley was a smoker and was happy to share a cell. The officer assessed that there were no issues over Mr McCauley sharing a cell. Mr McCauley was allocated a double cell on his own on A Wing, which is the reception wing.
19. In reception, Mr McCauley made a phone call to his father. The investigator has listened to this call. Mr McCauley told his father not to be upset, and that he was fine. He said staff had offered him vulnerable prisoner status but he had declined. He asked his father to book a visit, bring him clothes and to delete his Facebook account.
20. At an initial health screen, a healthcare assistant recorded that Mr McCauley had no physical or mental health issues, had no history of using drugs or alcohol, and had no history of self-harm. She noted that Mr McCauley was not prescribed any medication and had had four teeth extracted a week earlier. Mr McCauley gave consent for healthcare staff to obtain his community GP records.
21. On 22 March, a member of the chaplaincy team saw Mr McCauley as required as part of the induction process. He recorded that Mr McCauley had no issues or concerns and had no thoughts of self-harm.
22. On 23 March, a nurse saw Mr McCauley for a second health screen. She recorded that Mr McCauley had no physical or mental health issues, had not used drugs or alcohol, and had no thoughts of self-harm or suicide. She told the investigator that she did not consider that Mr McCauley was at risk of suicide.
23. A fellow prisoner told the investigator that he had arrived at Manchester on the same day as Mr McCauley. He said he knew Mr McCauley and his family as they came from the same area. He said that Mr McCauley appeared "happy-go-lucky". He said that Mr McCauley was candid about the reason he was in prison. He said that, after a couple of days, Mr McCauley was moved to D wing, while he remained on A Wing.
24. Another fellow prisoner told the investigator that he had arrived at Manchester on 22 March. He said that he and Mr McCauley had been friends for six years. He

- said that, when he arrived on A Wing, he saw Mr McCauley and they then shared a cell together. He said Mr McCauley had told him why he was in prison.
25. On 24 March, Mr McCauley was moved from A Wing to D wing. An officer told the investigator that he worked on D Wing and there were no issues or concerns about Mr McCauley and he was seen mixing with other prisoners.
 26. Prison Service records show that Mr McCauley made two telephone calls to his parents' number, on 25 and 26 March. The investigator has listened to both of these calls. The call of 25 March was initially answered by Mr McCauley's sister. They talked about his alleged offence and about his solicitor. Mr McCauley said he felt like killing himself. His sister told him to stay strong and said that she and their father were due to visit him on 5 April. Mr McCauley then spoke to his father. He told his father he had never felt so scared in his life and felt like killing himself. Mr McCauley's father told him to be strong and they then talked about his alleged offence and who might have contacted the police. During the call made on 26 March, Mr McCauley again spoke to his sister and father. They talked about the money that had been sent to him and which clothes they were to bring to the prison when they visited. On this occasion, Mr McCauley did not say anything about having thoughts of suicide or self-harm.
 27. On 27 March, at 10.15am, Mr McCauley moved into cell D-1-13 to share with another prisoner. He told the investigator that Mr McCauley was not "his usual self". Mr McCauley told him that the nature of his alleged offence was affecting him and he did not feel safe.
 28. That evening, at 6.03pm, Mr McCauley used his cell bell and told staff that he wanted to be placed on vulnerable prisoner status due to his offence. A supervising officer (SO) asked Mr McCauley whether he had been threatened but he said not. She told the investigator that she explained to Mr McCauley that a move would be arranged in the morning as he was safe with his friend, his cellmate.
 29. On the morning of 28 March, the SO arranged for Mr McCauley to move to the induction wing. However, Mr McCauley said he had changed his mind and was happy to stay on D Wing. She explained to Mr McCauley the support that was available to him as a vulnerable prisoner. Mr McCauley said he did not need any support and signed a disclaimer for protection which stated: "I have been advised of the options available to me regarding protection from the general population as a vulnerable prisoner. I have been informed and I am aware of the potential risks this may present to me. I decline this offer." Both the SO and an officer also signed the disclaimer. The SO and officer told the investigator that they saw Mr McCauley mix with other prisoners throughout the rest of the day and that they had no concerns about his welfare.
 30. That evening, at 5.49pm, Mr McCauley used his cell bell and told staff that he had changed his mind again and *did* want to be placed on vulnerable prisoner status. The SO told Mr McCauley that a move would be arranged the following morning.
 31. On 29 March, at 9.08am, Mr McCauley was moved from D wing to the vulnerable prisoners wing, where he occupied a cell on his own. Prison records show that

Mr McCauley made two telephone calls and the investigator has listened to both calls. At 11.38am, Mr McCauley spoke to his father. He said that he had moved to the vulnerable prisoner wing as other prisoners were aware of his alleged offence. He said he felt safer now and would tell his father about it when they met. At 4.38pm, Mr McCauley initially spoke his mother. She asked Mr McCauley whether he was ok and he told her he was. Mr McCauley then spoke to his father, who said he had spoken to Mr McCauley's solicitor and they were due to speak again the following day. Mr McCauley ended the call saying "Will call you tomorrow, love you Dad".

32. A fellow prisoner told the investigator that he was surprised to see Mr McCauley back on A wing. He said Mr McCauley told him that he had gone onto protection because of his offence. He said the last time he saw Mr McCauley was that evening when he gave Mr McCauley some tobacco. He said Mr McCauley gave no indication that he had thoughts of taking his own life.
33. Prison records show that Mr McCauley had three visits organised. These were on: 31 March with the Probation Service; on 1 April with Mr McCauley's legal representative; and on 5 April with Mr McCauley's father, mother and sister.
34. On 30 March, at 5.34am, an officer began the roll check at the end of the night shift. When she reached Mr McCauley's cell, she opened the observation panel and found that Mr McCauley had covered the glass with what appeared to be a blue towel. She said she ran to get help from an operational support grade (OSG). They were unable to get a response from Mr McCauley. The OSG used his radio to summon the assistance of other staff.
35. The OSG told the investigator he followed the local instructions at Manchester for opening cells during the night. These instructions say that there must be a minimum of three staff, and permission to unlock the cell must be given by the Night Orderly Officer (the person in charge of the prison during the night), unless there was an immediate danger to life.
36. At 5.38am, an officer and a custodial manager arrived. The officer kicked the cell door in order to get a response from Mr McCauley and, in as a result, the obstruction fell from the glass panel. He could see that Mr McCauley was hanging from the light fitting by a ligature made from bedding. He immediately entered the cell and the custodial manager used her radio to call a Priority 1 message to summon urgent medical assistance.
37. The officer cut Mr McCauley down and lowered him to the floor. He said that there were clear signs of rigor mortis as Mr McCauley's body was stiff and cold to the touch. He said that based on his first aid training, he knew it would have been futile to start cardiopulmonary resuscitation (CPR).
38. A nurse responded to the Priority 1 call and arrived at Mr McCauley's cell at 5.42am. She said that, on examining Mr McCauley, there were clear signs of rigor mortis and lividity (discolouration) and, based on her nursing experience, this indicated that Mr McCauley had been dead for some time.

39. Prison records show that the Priority 1 call was made at 5.39am, a 999 call was made 5.41am, that the paramedics arrived at 5.50am. The paramedics pronounced Mr McCauley dead at 6.02am.
40. Mr McCauley had left a suicide note addressed to his parents and sister. In it, he said he had lived a happy life but could not go on as he had not committed the offence with which he had been charged. He requested that his family wear white at his funeral and specified songs to be played at the service.

Contact with Mr McCauley's family

41. At 8.00am, the Governor, the Head of Offender Management Unit and a member of chaplaincy went to see Mr McCauley's parents at their home to break the news that Mr McCauley had died and to offer their condolences. In line with Prison Service instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

42. After Mr McCauley's death, the Head of Operations debriefed the staff involved in the emergency and offered her support and that of the staff care team.
43. The prison posted notices informing other prisoners of Mr McCauley's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide and self-harm, in case they had been adversely affected by Mr McCauley's death.

Post-mortem report

44. A post-mortem examination, the Home Office forensic pathologist confirmed that the cause of Mr McCauley's death was hanging. She noted that the toxicology results found no evidence of alcohol or illicit drugs.

Findings

Assessment of risk of suicide and self-harm

45. Prison Service Instruction (PSI) 07/2015, *Early Days in Custody*, states that it is a mandatory requirement for staff to manage prisoners who arrive with an indication that they might be at risk of suicide and self-harm appropriately. PSI 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, states that, after speaking to a prisoner, staff should use their judgement in combination with all available evidence to inform their decision as to whether a prisoner poses a risk to himself. Both instructions list a number of risk factors and triggers that might increase prisoners' risk of suicide or self-harm. These include first time in custody, a history of self harm, mental illness, illicit drug use and being charged with a serious sex offence.
46. Mr McCauley had been in prison before. He had no history of suicide attempts or self-harm and there was no record or indication of any history of mental illness. The reception officer and two healthcare staff assessed Mr McCauley when he arrived at Manchester. None of them considered that he was at risk of suicide, such that he needed additional monitoring and support using Prison Service suicide and self-harm prevention procedures. Mr McCauley was offered vulnerable prisoner status in reception but he declined. There was little to indicate that Mr McCauley was at particular risk and needed increased monitoring. We do not consider that staff at Manchester could have foreseen or prevented his actions on 30 March.

Clinical Care

47. The clinical reviewer noted that Mr McCauley had no history of self-harm or attempted suicide and had given no indication that he had any suicidal thoughts. She considered that the standard of care Mr McCauley received at Manchester was equivalent to the care he could have expected to receive in the community.

Emergency Response

48. PSI 03/2013, *Medical Emergency Response Codes*, issued in February 2013, contains mandatory instructions for efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of, and understand, the instruction and their responsibilities during medical emergencies. The PSI also includes a mandatory instruction that the terms of the medical emergency response protocols must be written and agreed in conjunction with the local healthcare commissioner at the prison and the local ambulance trust.
49. On 2 April 2016, the prison issued an updated Governor's Order about medical emergencies in response to Mr McCauley's death. However, we are concerned that it does not reflect the instructions in PSI 3/2013 and could lead to further delays. It stated: "ECR [the control room] automatically calls an ambulance only where it is certain one is needed. In all other cases Hotel One [emergency response nurse] will make that decision". We are concerned that the new instruction qualifies the need to call an ambulance automatically after a Priority 1

call, rather than asserting that it should be called immediately and automatically without waiting for further information.

50. On 30 March, there was a delay of two minutes between the Priority 1 message being relayed and an ambulance being called. We do not believe that this delay affected the outcome for Mr McCauley, as staff responded very quickly to the emergency and it was likely that Mr McCauley had been dead for some time when his cell was opened. However, in other cases, such a delay could be critical.
51. In our report into another self-inflicted death in 2016 at Manchester, we found the same issue regarding the emergency response and made a recommendation. We repeat that recommendation:

The Governor should ensure that the prison's local emergency protocol meets the requirements of PSI 3/2013, *Medical Emergency Response Codes*, and that the control room calls an ambulance immediately a medical emergency code is called, without waiting for further confirmation.

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