Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Denzel Schrader, a prisoner at HMP Manchester, on 5 April 2019

A report by the Prisons and Probation Ombudsman

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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*

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 I oversee can improve their work in the future.

Mr Denzel Schrader died after being found hanged in his cell at HMP Manchester on 5 April 2019. He was 48 years old. I offer my condolences to Mr Schrader's family and friends.

Mr Schrader had been remanded into custody on 26 October 2018 charged with serious offences against a family member. It was his first time in prison.

I have some concerns about the quality of the assessment of Mr Schrader's risk of suicide or self-harm when he first arrived at Manchester. I accept, however, that Mr Schrader took pains to hide his feelings and intentions from staff, and I am satisfied that staff could not have predicted Mr Schrader's actions in the days before his death.

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

Sue McAllister CB
Prisons and Probation Ombudsman **December 2019**

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Summary

Events

1. On 26 October 2018, Mr Schrader was remanded into custody at HMP Manchester, charged with serious sexual offences. He was 48 years old.

2. Mr Schrader had never been in prison before. He suffered from asthma and was prescribed inhalers.

3. Mr Schrader had no history of self-harm and was not assessed as posing a risk to himself. He settled well at Manchester, had a job in the workshops, and got on well with staff and his cellmate. He was also in regular contact with his son.

4. On or before 2 April, Mr Schrader appears to have told his son that he intended to take his own life. Mr Schrader's son did not pass this information to the prison.

5. On 5 April 2019, at 11.29am, a member of staff found Mr Schrader hanged in his cell. He requested an ambulance. Staff responded and began cardiopulmonary resuscitation. The paramedics arrived at 11.39am and at 11.45am, Mr Schrader was pronounced dead.

Findings

Assessment of risk

6. Although Mr Schrader had some risk factors for suicide and self-harm there is no evidence that staff considered managing him under suicide and self-harm procedures (known as ACCT) when he arrived at Manchester or when it emerged three weeks later that he had researched suicide methods before his arrest. We are concerned that staff relied too heavily on Mr Schrader's denial that he had suicidal thoughts.

7. We are also concerned that there is no evidence that staff had any meaningful engagement with Mr Schrader during his five and a half months on remand.

8. It is clear from Mr Schrader's telephone calls to his son, that he intended to take his own life for at least three days before he did so. Mr Schrader's son did not contact staff at Manchester to tell them about his father's plans. We are satisfied that Mr Schrader hid his intentions from staff and his cellmate.

9. Even if Mr Schrader had been managed under ACCT procedures when he first arrived at Manchester, we do not consider that prison staff could have predicted Mr Schrader's actions in the days leading up to his death.

Clinical care

10. The investigation identified no concerns with Mr Schrader's treatment while in custody. The clinical review also concluded that the care provided to Mr Schrader was equivalent to that he could have expected to receive in the community.

Recommendations

- The Governor and Head of Healthcare should produce clear guidance about procedures for identifying prisoners at risk of suicide and self-harm. In particular, this should ensure that reception, healthcare, first night staff and all others who assess risk:
    - Have a clear understanding of their 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 and self-harm, including information from the Person Escort Record (PER) and other sources; and
    - Document the information considered and the reasons for the decision on whether or not to open an ACCT.

The Investigation Process

11. 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.

12. The investigator visited Manchester on 19 December. He obtained copies of relevant extracts from Mr Schrader's prison and medical records.

13. NHS England commissioned a clinical reviewer to review Mr Schrader's clinical care at the prison.

14. The investigator interviewed four members of staff and one prisoner at Manchester in May 2019. Three interviews were jointly conducted with the clinical reviewer.

15. We informed HM Coroner for Manchester District of the investigation. He gave us the results of the post-mortem examination and toxicology results. We have sent the coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Schrader's son to explain the investigation and to ask whether there were any matters he wanted the investigation to consider. Mr Schrader's son did not raise any concerns and did not want a copy of this report.

17. A solicitor acting on behalf of Mr Schrader's wife subsequently asked for a copy of the report. The solicitor received a copy of the initial report and pointed out two factual inaccuracies. This report has been amended accordingly.

Background Information

HMP Manchester

18. 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 more than 1,200 men. Manchester Mental Health and Social Care Trust provides 24-hour nursing.

HM Inspectorate of Prisons

19. The most recent full inspection of HMP Manchester was carried out in June and July 2018. Inspectors reported that, compared to their last inspection in 2014, where the prison achieved reasonably good outcomes against their healthy prison tests, at this inspection there had been a deterioration in most outcomes.

20. Inspectors noted that self-harm had increased since their last inspection, and that there had been eight self-inflicted deaths since November 2014, three of which had occurred in the previous six months. Although most of the recommendations following the PPO's investigations into previous deaths had been actioned, inspectors were concerned that the recommendations had not been regularly reviewed. They recommended that action plans developed following death in custody investigations should be reviewed periodically to ensure that changes in practice and lessons learned were sustained over time.

21. Inspectors also found that, although the majority of staff were approachable and helpful, a small but influential number of operational staff were disengaged and demonstrated little respect for prisoners. The absence of personal officers or key workers was a missed opportunity. Many prisoners felt frustrated, anxious and unsupported. Inspectors recommended that all prisoners should have a single named member of staff assigned to them to support and encourage them to achieve their objectives.

22. Because of concerns about the prison's overall performance, inspectors returned 11 months later in June 2019 to conduct an Independent Review of Progress. They noted that there had been three further self-inflicted deaths in that time, and a fourth death was awaiting classification. They found that the investigations into these deaths indicated that recommendations from previous death in custody investigations had not been effectively implemented. Inspectors concluded that the prison had made no meaningful progress against their earlier recommendation.

23. They also reported that they saw very little relaxed engagement between staff and prisoners and that, during association and movement periods, staff usually stood together in groups, observing passively rather than taking the opportunity to engage with prisoners

Independent Monitoring Board

24. 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 annual report, published in October 2018, the IMB commented that while the physical condition of the prison was a concern, prisoners and their

well-being were treated as a priority. The IMB noted that, at times, wings had less than the standard level of staffing which adversely affected the prison regime.

Previous deaths at HMP Manchester

25. Mr Schrader was the fifteenth prisoner to die at Manchester in the past two years. Of these deaths, six were self-inflicted, seven were from natural causes and one is awaiting classification.

26. In previous investigations into self-inflicted deaths at Manchester, we identified weaknesses in the risk assessment of prisoners at risk of suicide and self-harm. We found in particular that staff placed too much emphasis on prisoners' presentation and did not give sufficient consideration to their risk factors.

27. Following a self-inflicted death in February 2018, we escalated our concerns to the Executive Director for the Long-Term and High Security Estate. He said in response that his Group Safer Custody team would work with the prison's Safer Custody team to ensure that actions to address the PPO's recommendations were implemented.

Key Events

28. On 26 October 2018, Mr Denzel Schrader was remanded into custody at HMP Manchester charged with serious sexual offences against a child (a family member). Mr Schrader had not been in prison before. Mr Schrader was 48 years old, suffered from asthma and was prescribed inhalers. He had no history of self-harm.

29. When Mr Schrader arrived at Manchester, he saw an officer in reception. The officer recorded that this was Mr Schrader's first time in custody. Mr Schrader told the officer that he had no thoughts of self-harm. The officer completed the cell sharing risk assessment which assessed that Mr Shrader presented a standard risk of harm to others. The officer recorded that Mr Schrader was on remand, had no self-harm issues, and was aware of the support available to him at Manchester.

30. Due to the nature of Mr Schrader's alleged offences, the officer assessed that Mr Schrader was significantly vulnerable to assault from other prisoners. The officer completed the request for vulnerable prisoner (VP) status form. The Duty Governor approved Mr Schrader's VP status, recording that it was appropriate due to the nature of his alleged offences. At Manchester, all prisoners granted VP status are located on the same wing and kept apart from the main prison population.

31. During reception, a healthcare assistant completed Mr Schrader's initial reception screen template. He recorded that this was Mr Schrader's first time in custody and the only healthcare issue identified was his history of asthma. Mr Schrader said he had no thoughts of self-harm or suicide. He completed an alcohol audit screen (a simple tool to establish whether alcohol use is a problem). Mr Schrader scored 1, which indicated that he had no significant alcohol problem. He denied any drug use and declined to be referred to substance misuse services. Although Mr Schrader was a smoker, he declined to be referred to smoking cessation services.

32. A prison GP saw Mr Schrader in reception and repeated his prescribed medication of sirdupla (an asthma inhaler) and salbutamol (another asthma inhaler). Mr Schrader was allowed to hold these medications in his possession.

33. On 29 October, a pharmacist received Mr Schrader's community GP records. These confirmed the prescription of inhalers for asthma. There were no other health concerns recorded and no history of self-harm.

34. Between 30 October and 4 April 2019, Mr Schrader continued to receive his prescribed medication and had asthma reviews with healthcare, the last being held on 12 February 2019. This was Mr Schrader's last interaction with a member of healthcare before his death on 5 April.

35. On 16 November, the prison's Safer Custody team recorded that the police who were investigating Mr Schrader's alleged offences had informed her that there was evidence that Mr Schrader had been researching 'how to commit suicide' on the internet before his arrest. She submitted an intelligence report and informed the Supervising Officer on Mr Schrader's wing.

36. Later that day, an officer recorded that, in the light of this information, she spoke to Mr Schrader about how he was doing on the wing and in prison and he said that “everything was fine and he had no thoughts of self-harm of suicide”.

37. Prisoner X told the investigator that he and Mr Schrader had shared a cell on the VP wing since they had arrived at Manchester on 26 October 2018, and that they got on very well. He said that Mr Schrader had a job in the workshops in the mornings and that he had a job in the workshops in the afternoons. He said Mr Schrader got on well with other prisoners, was not bullied, was in regular contact with his son and gave no indication he had thoughts of self-harm or suicide. He said that if Mr Schrader had given him any indication that he was going to harm himself he would have told staff.

38. An officer on the VP wing, told the investigator that he knew both Mr Schrader and prisoner X well. The officer said both Mr Schrader and prisoner X were friendly, there were never any problems between them, and they were friendly and co-operative with staff. The officer said that at no time did Mr Schrader give any indication that he was at risk or had thoughts of self-harm or suicide.

39. A Supervising Officer (SO) said that she was in charge of the VP wing. The SO said that Mr Schrader did not cause staff any difficulties. Mr Schrader and prisoner X got on well together and complied with whatever staff asked of them.

40. Mr Schrader’s prison phone records show that he was in regular phone contact with his 23-year-old son. Mr Schrader’s phone calls to his son were not monitored by prison staff. Mr Schrader’s son also visited his father at Manchester. Mr Schrader was placed on closed visits on 14 December after he was suspected of receiving an unauthorised article from his son. He remained on closed visits until 7 March 2019. He received his last visit from his son on 2 April.

41. The investigator listened to each of the phone calls Mr Schrader made on 4 April. The first call, made at 5.13pm, lasted 13 minutes and 56 seconds. Mr Schrader asked his son if he had “typed that thing up yet” and his son replied “no”. Mr Schrader told his son not to forget what they had talked about. Mr Schrader’s son played a song that Mr Schrader wanted to hear. Mr Schrader told his son to take care of himself and be strong. He asked his son to forgive him, said that he loved him and ended the call saying, “It needs to be done, love you, bye.”

42. The second call, made at 5.52pm, lasted two minutes and 51 seconds. Mr Schrader asked his son if he had transferred money and confirmed that his son had access to his Facebook account. Mr Schrader’s son asked his father to contact his solicitor to discuss his case, and they talked about the courts being open at 9.00am. Mr Schrader ended the call saying, “Take care of yourself, bye.”

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43. Prisoner X said he last spoke to Mr Schrader at 8.30am, before he went to work in the workshops. He said Mr Schrader seemed his usual self and gave no indication that he intended to take his own life.

44. At 8.57am, Mr Schrader called his son. This call lasted one minute and 14 seconds. Mr Schrader asked his son how things were and what size shoes he took. Mr Schrader's son said he was "ok" and that he took size nine shoes. Mr Schrader said, "Oh ok then, these are nice boots." Mr Schrader ended the call by saying, "I'm going to get it done, I love you, bye."

45. The evidence from the phone calls indicates that Mr Schrader intended to take his own life and that he had discussed this with his son before 4 April. Mr Schrader's son did not contact Manchester to alert staff to his father's intentions.

46. At 11.29am, prisoner X returned from the workshops and the officer opened Mr Schrader's cell to let him in. The officer saw Mr Schrader hanging from the window bars with a ligature made from bedding. The officer immediately radioed a code blue emergency, which indicates a prisoner is unable to, or having difficulty breathing and an ambulance was called immediately.

47. Staff responded, cut Mr Schrader's ligature, lowered him to the floor and started cardiopulmonary resuscitation (CPR). Within two minutes two nurses arrived and took over the CPR. They used an automated external defibrillator, which administers electrical shocks to restore a normal rhythm to the heart if any is found. The defibrillator found no shockable rhythm, so the nurses continued with CPR.

48. North West Ambulance records show that the 999 call was received at 11.29am, and paramedics arrived and took over Mr Schrader's care at 11.39am. At 11.45am, Mr Schrader was pronounced dead.

49. Mr Schrader had left a note in his cell to indicate his wishes for the disposal of his estate following his death.

50. On 6 April, at 3.48pm, a lengthy post appeared on Mr Schrader's Facebook account which began, "Words Unspoken: True story by Denzel Schrader about the allegations in September 2018. He is in a better place now and will be missed greatly. RIP." The post, which appeared to have been written by Mr Schrader, said that the allegations against him were false, that he had been "killed by lies and love", that he had suffered more pain than he had ever thought possible over the last six months and could not endure it any longer, and that he had only waited as long as he had because he had hoped that his alleged victim might come to their senses and admit the truth. It ended, "So I go to this painful death with a pure heart, knowing that my only sin was love. God forgive me for what I have to do, but I cannot live like this."

51. The police established that the post had been uploaded by Mr Schrader's son. It was removed some days later.

Post-mortem report

52. A post-mortem examination found that the cause of Mr Schrader's death was hanging. The toxicology results showed that Mr Schrader was not under the influence of any illicit drugs or alcohol at the time of his death.

Contact with Mr Schrader's family

53. Two family liaison officers from HMP Manchester, visited Mr Schrader's son at his home address at 2.08pm on 5 April. They broke the news of his father's death and offered condolences. In the days that followed, Manchester kept in touch with Mr Schrader's son and, in line with Prison Service instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

54. The Head of Security, held a debrief for staff involved in the emergency response, including healthcare staff, to ensure they had the opportunity to discuss any issues arising, and for managers to offer support. The staff care team also offered support.

55. The prison posted notices informing staff and prisoners of Mr Schrader' death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Schrader's death. Prisoner X told the investigator said he received excellent support from staff in the days after Mr Schrader's death.

Findings

Assessment of risk

56. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* which sets out the Prison Service's framework for delivering safer custody procedures, lists a number of risk factors and potential triggers for suicide and self-harm. These include a prisoner's first time in custody, recall to custody, early days in custody, previous self-harm, being charged with a violent offence, a history of alcohol or drug abuse and court appearances, especially at the start of a trial and sentencing. Staff should interview new prisoners in reception to assess their risk of suicide or self-harm. All staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns, including opening an ACCT if necessary.

57. Mr Schrader had some risk factors for suicide and self-harm in that this was his first time in custody and he had been charged with serious offences against a family member. There is no evidence that these risk factors were considered by staff in reception. We cannot say that Mr Schrader should definitely have been managed under suicide and self-harm procedures (known as ACCT) when he arrived at Manchester but we would have expected the possibility to have been considered. Instead, staff appear to have relied solely on the fact that Mr Schrader said he had no suicidal thoughts.

58. We would also have expected to see greater consideration of Mr Schrader's risk factors when it emerged three weeks later that Mr Schrader had researched methods of suicide before he was arrested. Again, staff seem to have relied solely on his assertion that "everything was fine and he had no thoughts of self-harm of suicide".

59. We recommend:

The Governor and Head of Healthcare should produce clear guidance about procedures for identifying prisoners at risk of suicide and self-harm. In particular, this should ensure that reception, healthcare, first night staff and all others who assess risk:

- **Have a clear understanding of their 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 and self-harm, including information from the Person Escort Record (PER) and other sources; and**
- **Document the information considered and the reasons for the decision on whether or not to open an ACCT.**

60. We are also concerned that, apart from a single conversation on 16 November, there is no evidence that staff had any meaningful interactions with Mr Schrader

during his five and a half months on remand. This would have made it difficult for staff to assess whether he posed a risk to himself.

61. Having said that, we recognise that Mr Schrader appears to have taken pains to hide his feelings and intentions from staff and his cellmate, even though it is clear from his phone calls to his son that he had decided to take his own life from at least 2 April. Even if Mr Schrader had been managed under an ACCT when he first arrived at Manchester, it seems unlikely that this would have continued for long or that it would have prevented his suicide more than five months later.

62. It follows that we do not consider that staff at Manchester could have predicted that Mr Schrader intended to take his life on 5 April.

Clinical Care

63. The clinical reviewer is satisfied that Mr Schrader received care that was equivalent to the care that he would have received in the wider community. Mr Schrader had asthma reviews in line with national clinical guidance. Mr Schrader had no issues with drugs or alcohol. He had no mental health issues and there was no indication that he was at risk of self-harm or suicide.

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