

**Investigation into the circumstances surrounding the
death of a man
at HMP Wolds in May 2009**

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

December 2009

This is a report into the circumstances surrounding the death of a man in May 2009. He was a prisoner at HMP Wolds and died only two days after he arrived there (although he came into prison seven months earlier). He was found hanging in his cell shortly after it was unlocked for the morning.

I extend my condolences to the man's family and friends. The prisoners at Wolds held a memorial service on the day that he was buried as a gesture of condolence.

The investigation was carried out by my colleague. In addition, one of my family liaison team has been in contact with the man's family and partner to tell them about the Ombudsman's investigation and ask whether they had particular questions about his time at the Wolds.

As part of the investigation, a clinical review was undertaken on behalf of the PCT, I am most grateful to the clinical reviewer. The Director of Wolds should consider reviewer's findings and recommendations as well as those in this report.

The man had offended from a young age and spent previous periods in custody. When he arrived at Wolds, he was assessed as having no physical or mental problems, was not taking any medication and was not considered to be at risk of harming himself. In the very short time he spent on the Induction Unit, no concerns were raised about his well being.

He may have felt anxious about his relationship with his partner as he made several telephone calls to her in this short space of time. He also wanted her to visit him as soon as possible. The man was found with a note addressed to her, which said that he could not live without her. It appears that these feelings were the trigger for his actions.

I make six recommendations regarding the roll check and emergency code procedures, and the use of medical equipment in Wolds.

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SUMMARY

The man was arrested in December 2008 for burglary. At the time, he was on licence and so he was recalled to prison. He was convicted and sentenced to three years imprisonment. He started his prison sentence in HMP Leeds, before moving to HMP Lindholme and transferring to HMP Wolds on Wednesday 6 May 2009. He had no previous self harm history.

When the man was screened at the prison reception, he was not taking any prescribed medication and had no ongoing medical conditions. He gave no indication that he had suicidal thoughts and denied any intention of hurting himself. He was located on the Induction Unit where he began to receive his prison induction. He settled on the wing quickly.

The man telephoned his partner on his first evening followed by several phone calls the next day. From the content of the calls (of which were read by the investigator), he appeared to be missing her and was concerned about their relationship. However he raised no concerns with staff. The Induction Unit is a small unit, and the prison custody officer who had the most contact with him said that his behaviour caused no concern. The officer facilitated the man's last telephone call to his partner on the evening before he took his life and did not detect any sign that he would harm himself.

On the morning of Friday 8 May, the night duty officer carrying out the morning roll check at around 6.30am was interrupted by a cell bell alarm. Having responded to it, he discovered that no cell bell had actually been activated, but that there was a fault on the system in the office. The officer dealt with the problem and returned to the Induction Unit to complete the roll check. At the time, he believed that he had checked the man's cell.

The man's cell was unlocked at around 8.10am by the day shift prison custody officer who opened the door slightly. The officer saw lumps in the bed and thought that he was asleep. A few minutes later, a fellow prisoner realised that the man had not come to collect his breakfast and decided to go to his cell to see if he was alright.

The prisoner went into the cell and discovered the man hanging by a ligature made from torn bed sheets tied to the light fitting in the centre of the ceiling. Despite staff arriving quickly and carrying out cardio pulmonary resuscitation (CPR), he was pronounced dead at 8.30am.

A note with his partner's name was found after the man's death which suggests he took his life as he could not live without his partner.

This is the second death to have occurred at Wolds since April 2004 when the Ombudsman began investigating all deaths in prison custody. The circumstances of the previous death were natural causes and, although there is no connection between the two cases, one of the earlier recommendations is referred to in this report.

THE INVESTIGATION PROCESS

1. The Ombudsman appointed one of his investigators to investigate the circumstances surrounding the man's death. As the investigator was unavailable, the investigation was opened by a colleague, on 15 May 2009. The investigator was later briefed by his colleague, of the outcome of the visit and handed over documentation.
2. The investigator's colleague met the Director and some of his staff. Notices of the investigation and terms of reference had already been sent to the prison and invited anyone with any information to contact the investigator. The investigator's colleague also met the Deputy Controller, the chair of the Independent Monitoring Board (IMB), Healthcare Manager, and union representatives. He visited all parts of the prison including the wing where the man lived. The Duty Director was appointed as the prison's liaison officer.
3. The man's prison records, including his medical record, were made available to the investigator's colleague during his initial visit to the prison. Additional documents were made available to the investigator when he returned to conduct interviews.
4. A clinical review was commissioned from the PCT, into the man's medical care. I am grateful to the Public Health Lead for her review. As part of the review she was provided with the man's prison medical records and interview transcripts from interviews conducted by the investigator.
5. One of the Ombudsman's family liaison officers contacted the man's parents and his partner to inform them of the investigation and give the opportunity to raise any questions or concerns about the care he received.
6. When the investigator and family liaison officer visited the man's parents they asked if his history of harming himself had been taken into consideration during his reception check at Wolds. However no record of the man self harming has been found in the prison documents received by the investigator. The family also wanted to know if there were any concerns regarding him not eating. His medical records for HMP Leeds noted in August 2006 that he was underweight. In November 2006, when he was in HMP Lindholme, his medical record noted he was not eating properly. There were no concerns recorded at Wolds about his eating habits.
7. The family liaison officer was disappointed to be told by the man's father that he left several messages with the prison after his son's death which were not returned. He was trying to get his personal belongings back and I am pleased to learn that this matter has since been resolved.
8. Following a meeting with the family and their solicitor, they wished to express their concerns that the cells in the induction unit contained ligature points. It was felt that cells, particularly in this location, should be made safer due to the increased risk of suicide when prisoners first arrive in prison.

9. I hope this reports provides the man's family and partner with a better understanding of the events leading to his death.

HMP WOLDS

10. HMP Wolds opened in early 1992 as a remand prison, but in 1993 its function changed to a category B local prison. It has since been changed to be a category C training prison with a particular function of serving the needs of second stage life sentenced prisoners.
11. Wolds is operated by the private firm G4S and accommodates 395 adult male prisoners aged over 21 years who are serving medium to long term sentences. The prison offers several courses designed to address offending behaviour and a variety of daytime and evening education classes, as well as more mainstream skills training in workshops.
12. Healthcare services are provided by Primecare under a contract with G4S. Primecare provide nursing cover throughout the core day, from 7.30am until 8.30pm, on Mondays to Thursdays. On Fridays, nursing staff are on duty from 7.30am until 6.00pm and at weekends from 8.30am until 4.30pm. There are no in-patient services at Wolds.
13. Wolds received an unannounced follow up inspection by HM Chief Inspector of Prisons in September 2007. In her report, HM Chief Inspector of Prisons wrote that Wolds deserved considerable praise for the work they had done to build on the strengths identified at the previous inspection and for acting on the areas requiring improvement. Healthcare services were described as 'reasonable'.
14. The Prison Service quarterly performance ratings for 2008 and into 2009 show that Wolds' performance rating was a level 2, which means that the prison has areas that require development. The performance rating increased to level 3 for 2009 -2010, indicating a good performance, and applied at the time of the man's death.

Admissions and Induction Unit

15. When prisoners arrive at Wolds, they come in through the Admissions Unit. Staff carry out various interviews and assessments whilst checking personal details. Prisoners then move onto the Induction Unit.
16. The Induction Unit is small, holding up to 14 prisoners at any one time. In addition, the wing has two cleaners (prisoners) who also assist during the induction programmes. Induction staff carry out further interviews and risk assessments and the prisoner is also assessed by a member of the healthcare team. Any immediate needs are identified and referrals made to the relevant agencies to offer support. The prisoner is then allocated a cell. The induction period lasts about three days during which prisoners will see a range of agencies introducing them to the services available in the prison. Once the induction period is completed, the prisoner is located on a normal residential wing.

Assessment, Care in Custody and Teamwork (ACCT)

17. The ACCT system aims to monitor and support prisoners assessed as at risk of suicide or self harm. Once placed on ACCT, the prisoner is observed at intervals determined by their level of risk. Wold's local procedure states a "level one" review would result in constant observation, whereas a "level two" would mean regular observations as deemed appropriate by the reviewing officer. The observations continue during the day and the night.

Cell observation panel

18. All cell doors in the Induction Unit have an observation panel so staff can see prisoners in their cell. The panel is a large slot which contains a smaller glass view flap, measuring about two inches. The small glass flap is used first when checking prisoners. If a better view is required, staff can open the large slot flap. There is also an additional spy hole to the left of the cell door which looks into the toilet area. For safety reasons, before entering a cell, staff are expected to look through the panel first.

Cell sharing risk assessment (CSRA)

19. In order to make sure that unsuitable prisoners do not share cells (for example a racist prisoner and one from a visible ethnic minority or a mentally disturbed prisoner with a violent one), a cell sharing risk assessment form is completed by reception staff when a prisoner first arrives at the prison.

First response team

20. There are three to four general duty staff appointed every day as members of a first response team who immediately respond to any emergencies within the prison. Healthcare staff are not included in this team.

Healthcare emergency code

21. If an emergency arises and healthcare staff are needed, the codes 1, 2, and 3 are used. Healthcare staff carry radios which are referred to over the radio net as "Hotel" followed by a number and then the emergency code. Code 1 would inform healthcare that they should take the triage bag (which contains emergency equipment, medications, blood pressure cuffs, temperature gauge and adrenaline), oxygen and defibrillator to an emergency. Code 2 refers to needing oxygen and the triage bag and Code 3 is for the triage bag only. These codes are shown on laminated pictures displayed on all units in the prison.

Listeners

22. Listeners assist prisoners who require additional support at any time in their period in custody. They are provided with training from the Samaritans to support them in this role. The service they provide is confidential.

Roll check procedure

23. The roll check is the physical count of the number of prisoners on each wing within a prison. Roll checks occur at specified times during the day and night, and staff must sign that the roll is correct. Wolds has a local operational instruction policy regarding roll checks and the key points are outlined below:
- “The prison roll will be checked daily on at least four occasions, as follows:
 - Before morning unlock, 7.00am
 - At lunch, 11.30am (11.00am Friday, 11.15am weekends, 10.15am last Friday in month)
 - At tea, 4.45pm (5.45pm Fridays and weekends)
 - After lock up at night 8.15pm (8.45pm Friday, Saturday, Sunday)
 - “Staff must satisfy themselves that an offender is actually present by obtaining a clear view of their face, if necessary by waking them to avoid counting a lump in the bed.
 - “At lock up and unlock, staff must satisfy themselves of the offender’s well being, by making a physical check of the offender and, where possible, physically speaking to the offender(s).”

KEY FINDINGS

Prior to arrival at the Wolds

24. The man was released in June 2006 from a two year and 11 month sentence for burglary. He was recalled two months later in August 2006, to HMP Leeds, after being arrested and charged with further offences. When he arrived at Leeds it was noted that he was underweight, drank 12 cans of alcohol each week and had no history of drugs.
25. Three months later (November 2006), the Crown Court ordered that the man serve a further prison sentence of three years and so he was taken to HMP Lindholme. When he arrived, he admitted to taking drugs, although the last time was five months previous. He denied any thoughts of wanting to harm himself. It was noted that he was not eating properly. No other concerns were raised.
26. Having been released on licence on 14 March 2008, the man was again arrested in December 2008 for burglary offences. He was recalled and remanded in custody to appear before a Crown Court on 12 December. Following his court appearance, he was convicted and sentenced on 13 January 2009 to three years imprisonment.
27. The man started his prison sentence in Leeds before returning to Lindholme on 9 February 2009. When he arrived there he went through the normal prison reception process. Staff noted on prison documentation that there were no issues of concern and his cell sharing risk assessment (CSRA) indicated he was a "low" risk. He was seen by a member of the healthcare team and did not mention any substance misuse or mental health problems. The comment "reception: no concerns" was noted on his medical records.
28. On 15 April, the man's solicitor wrote to Lindholme. The solicitor was concerned that his safety had been compromised because of an incident that had occurred. They recommended that he should be transferred to HMP Wolds. The prison replied (by e-mail dated 23 April) that, although they were aware that he had asked for a transfer, he had not mentioned any threats to his safety. The prison said it would contact Wolds to try to speed up the transfer process.
29. The Acting Deputy Head of Residence wrote a further letter to the man's solicitor dated 30 April. He said the man had been interviewed and provided with appropriate support. He was offered a move within the prison to ensure his safety until a transfer could be arranged. However, he refused to move to either the Care and Separation Unit or the Vulnerable Prisoner Unit and said he felt safe in his current location, the Induction Unit.
30. No other issues had been raised by the time he transferred to Wolds and he did not harm himself at any time.

The man's arrival at HMP Wolds

31. The man arrived at Wolds on the afternoon of Wednesday 6 May and went through the prison reception and induction process. He was initially interviewed by the staff in the Admissions Unit. It was recorded on the First Night Risk Assessment document that Lindholme had not mentioned any history of self harm and he was not currently on an open Assessment, Care in Custody and Teamwork (ACCT) document. He said he had no thought of suicide or wanting to harm himself.
32. The assessment document was passed on to a member of the healthcare team (HCA). At interview with the investigator, the HCA said she interviewed the man on the Induction Unit and completed a "First Night Risk and Needs Assessment". She had sight of his previous prison medical record from Leeds and Lindholme. Neither highlighted any previous risks related to suicide or self harm.
33. The man told the HCA that he had no mental health problems, had never harmed himself and was not taking any medication. He said that he drank alcohol and smoked, but denied having any problems with drugs, despite the documented evidence of substance misuse from his prison medical records in 2006. (It is unclear whether his previous records were taken into consideration during the Reception Health Assessment.)
34. The HCA thought that the man seemed to be in a good mood, joking about how skinny he was and describing a previous incident of being bitten by a police dog. He expressed no problems aside from mentioning that he thought his partner was "messing around". He was given the option to see the prison doctor but said he had no reason to. The HCA had no reason to refer him to see the registered nurse or the doctor on duty, although he did want to make an application to see the dentist.
35. The man's healthcare assessment lasted between 20 to 30 minutes. The HCA completed the healthcare section on the CSRA document and indicated that the man was a "low" risk and suitable for a multi occupancy cell. He was then passed onto the induction officer for a secondary assessment.
36. At interview with the investigator, the induction officer said he interviewed the man and completed the First Night Risk Assessment document. He displayed no indication of wanting to harm himself, his mood was good and he had no problems relating to the misuse of drugs or alcohol. He appeared "quite happy" to be at Wolds.
37. The induction officer went through a checklist of information about what the man could expect at Wolds. This included telling him about the services the prison had to offer as well as its regime. An assessment established that he did not have any immediate needs. He was provided with his first night provisions which included information booklets, toiletries, five pounds of credit on the PIN telephone and clothes.

38. A fellow prisoner told the investigator that he introduced himself to the man shortly after he arrived. As the wing cleaner, he provided him with information about the induction unit and reminded him that, if he needed anything, he could assist him.
39. At 6.16pm, the man telephoned his partner. (The content of this and a further seven telephone calls became known to the prison service after his death.) In this call, he explained that he was in Wolds and asked his partner to book a visit to see him on either Friday, Saturday or Sunday and to bring some of his clothes. He said he had not eaten or slept for four days and had tried to ring her earlier but her mobile telephone was switched off. His partner explained that she had left it at home. His response was that he thought she had been with someone else. They also spoke briefly about his partner's son.
40. The induction officer said the man quickly settled on the unit. He also got on well with the other prisoners on the wing and did not hesitate to ask questions of staff.
41. During the evening, the induction officer asked the man whether he had any preferences about which wing he would like to move to once he had completed his induction. (Prisoners normally stay on the induction unit for about three days and, whenever possible, staff try to locate them to a wing of their preference.) He said he wanted to go to B wing (the voluntary drug testing unit) because he had a friend there at the time.
42. Around 8.15pm, the induction officer carried out the evening roll check. The night staff came on duty at around the same time and confirmed the roll check numbers with him whilst he conducted a handover and updated them about any issues on the wing. As a matter of practice, the induction officer said that on a prisoner's first night, the large flap on their cell door would be left open so that staff could easily observe them during the night.
43. A Prison Custody Officer (PCO) told the investigator that he was on duty at night on the Induction wing. He would normally arrive around 8.15pm for a night shift. He said that one of his first tasks after receiving a handover was to conduct a roll check at about 8.20pm. He would check that all the cell doors were locked and open the hatches to make sure that the right prisoners were in the cells. If a prisoner could not be seen through the hatch, he would check the spy hole in case they were in the toilet area. The PCO said he did not necessarily check prisoners for signs of life if they appeared to be sleeping unless they were on an ACCT or "suicide watch". He would then radio the Control Room with his roll check numbers. The PCO recalled no incidents raised during the night through to the morning of 7 May.

Events on Thursday 7 May

44. The PCO carried out his morning roll check as usual around 6.30am. No problems were reported and he gave a verbal handover to his PCO colleague when he came on duty.
45. At interview with the investigator, the PCO colleague said that he unlocked the cells in the induction wing for breakfast at 8.00am. This was his first contact with the man and he raised no concerns about his well being. The PCO colleague said that, as this was a small unit, it was easier to notice prisoners and on this morning, none of them gave him any cause for concern.
46. The man's induction continued and he was interviewed by the prison chaplain, between 9.00am and 9.30am. The chaplain told the investigator that it was part of his role to speak individually with all new prisoners as part of their induction and to offer any support they might need.
47. The chaplain described the man as arriving for their meeting in a happy mood. He said he was okay and had slept well. They spoke for 20 minutes and he talked about his partner's son and his family saying he had no concerns about being at Wolds. Throughout the duration of the meeting, the chaplain said there was nothing in the man's demeanour that worried him.
48. At 10.47am, the man made his second telephone call to his partner. He told her to remember to book a visit to the prison before midday. He said he was fine but had no money. Shortly afterwards (between 11.00am and 11.30am), he and other prisoners had a period of association in the exercise yard. (This was the first time he had socialised with other prisoners outside the Induction Unit.) The chaplain saw the man in the yard and thought he appeared to be getting on well with other prisoners. After association, all prisoners collected their lunch and returned to their cells. He was a single occupant in a double cell. When the PCO colleague locked the man in his cell after lunch, he raised no concerns.
49. After the lunchtime break, prisoners were allowed out of their cells. At 1.52pm, the man made his third telephone call to his partner at her place of work. The telephone was answered by one of her colleagues or a switchboard operator. He was put on hold, but after waiting for a period of time, he ended the call.
50. Three minutes later (at 1.55pm), the man telephoned his partner's mobile phone. She said that she was unable to get a visiting order to see him until the following Sunday. He was unhappy with this and the following conversation included them swearing at one another. In response to a question from him, his partner said she could not go to the prison on weekdays because her son had to go to school. She complained that the man was always "whinging and moaning" at her and was upset that he believed she was having a relationship with someone else. Both then suggested that the relationship was over. With 99 pence telephone credit left, his partner said that she would drop off his "stuff" (clothes) at the prison but

did not reply when he asked if she would stay for the visit. He ended their conversation by asking her to “e-mail me tonight”.

51. At 2.06pm, the man made a fifth telephone call to his partner. In a short conversation, he again asked her to e-mail him that night and, although she still appeared to be unhappy, she agreed. Both said that they loved one another and the call ended.
52. The man made his sixth telephone call to his partner eight minutes later at 2.14pm. He apologised for being “nasty” and said it was because he had a “lot going on in my brain over the last few days”. He confirmed that his partner was bringing his clothes on her visit. With telephone credit of 30 pence remaining, they ended the call.
53. The fellow prisoner, as the Listener co-ordinator in the prison, spoke with the man during the day to explain his role as a Listener. The man raised no concerns and the fellow prisoner described him as “very friendly, happy, loud, shouting out of the windows to his friends on B unit”. (B Unit is opposite the Induction Unit, and the windows face each other.)
54. The man made a seventh call to his partner at her place of work at 3.14pm. He said he only had 18 pence telephone credit left and did not like the way their last call had ended. He explained that he had just written a long letter to her and then talked about the prison allowing family visits and running family courses that his partner could attend with him. Before the call ended, they both said that they loved each other and he asked her to e-mail him that night. His partner agreed and, as they ended their telephone call, his credit ran out.
55. The PCO colleague could not recall the exact time, but the man approached him towards the end of the afternoon. He said he was worried because he only had a small amount of telephone PIN credit left and wanted to contact his partner to make sure that she brought him some money when she visited him. The PCO colleague told him not to worry and said he would allow him a free three minute telephone call later that evening. He said he was “more than happy” with this.
56. The fellow prisoner saw the man out in the exercise yard around 6.15pm with some other prisoners. He was wearing a bright yellow shirt. The man returned to the induction unit at 7.15pm and went to make a telephone call. The fellow prisoner said that it appeared that the man was not having much luck contacting the person he was calling and the PCO colleague told him to leave it for a couple of minutes and try again later. He went back to his cell.
57. All prisoners except the cleaners on the Induction Unit are locked in their cells around 7.15pm. Cleaners remain out to complete their work and are locked in their cells around 8.00pm, shortly before the time the night staff commence their duty.
58. The PCO colleague unlocked the man to make his telephone call at 7.40pm, lasting for approximately one minute. (On this occasion he had attempted to

contact his partner once more, at her place of work, but she did not answer her telephone.) The fellow prisoner said he noted the man using the telephone and the PCO colleague standing nearby. After he had finished, he remarked to the fellow prisoner that “oh she wants to come and visit me now”. The PCO colleague said he did not know if he managed to speak with his partner, but he thanked him for allowing him to use the telephone. (Whilst escorting him back to his cell,) the PCO colleague said they chatted and he displayed no sign of any worry. The fellow prisoner the man were both locked in their cells at around 8.00pm.

59. The PCO colleague said that he had seen the man most of the day. He described him as “laughing and joking and chatting”. There was nothing about his demeanour that he might contemplate taking his life. The Director of Wolds told my colleague that the man gave the PCO colleague a sealed letter addressed to his partner that evening, the PCO colleague could not recall this. Such letters would normally just be placed in the post out tray.
60. The PCO arrived for his night duty and he carried out his roll check as normal. No problems were reported.

Friday 8 May

61. Each cell contains a cell bell for prisoners to use if they need assistance. The PCO said he recalled no serious incidents during the night and only attended a few cell bells in the Segregation Unit. When a cell bell is activated by a prisoner it makes a buzzing noise and registers on a display panel in the wing office. A red light also comes on outside the cell in question. The officer responds by going to the cell. Each cell has a night light in the centre of the room, with a switch outside the door used if an officer requires more light to see inside the cell.
62. The PCO began his morning roll check at around 6.30am. A cell alarm was activated whilst he was conducting the check on the Induction Unit. He could not see any red lights on the induction wing, so thought that it must have been activated by a prisoner on the Segregation Unit. He went to the wing office to confirm this. There was no indication that an alarm had been activated on the Segregation Unit either, so the PCO returned to the office and cancelled the alarm. The PCO told the investigator that the cell bell alarm system had a built in tamper alarm and this was not the first time that it had been wrongly activated. The PCO said that the system error had since been rectified.
63. The PCO said that he still had three cells to check when the alarm went off. On returning to the Induction Unit, he believed he checked the remaining cells. In hindsight and at interview, he could not actually recall if he completed the checks of the remaining cells, one of which was occupied by the man.
64. Shortly afterwards a third PCO arrived in the Induction Unit to say that he had finished his roll check. Both officers contacted the Control Room to confirm

their respective roll checks. A fourth PCO arrived for duty at about 7.00am, a handover was completed and the PCO left the prison shortly afterwards.

65. The fellow prisoner said that, because of his cleaning duties, he would normally get up quite early in the mornings and be ready for his cell to be unlocked to start work. He told the investigator that, on this morning, he did not recall a roll check being made of his cell.
66. At interview with the investigator, the fourth PCO said that no incidents or concerns were raised during the handover. He proceeded to carry out some paperwork, which included the man's final induction checklist. (The document was to be completed before he moved to a residential wing and was a check that he had received his full induction.) No problems had been identified and it was expected that he would move later that day. The induction officer came to the unit just before 8.00am and they looked through some of the prisoners files and discussed which of them would be located to the residential units.
67. At approximately 8.00am, the fourth PCO unlocked the two cleaners, including the fellow prisoner, to prepare the breakfast for other prisoners. Having completed his task by 8.10am, he told the fourth PCO that he could unlock the rest of the prisoners so they could collect their breakfast. The fellow prisoner saw the fourth PCO unlock the cells. He said he saw the PCO unlock and open each door approximately "two inches" only. He did not see the PCO physically check upon or call the name of any each prisoner. The fourth PCO told the investigator he unlocked each cell door and looked in.
68. The man's cell number 2-14 was the last to be unlocked. The fourth PCO recalled that his bed was on the left hand side of the room, and having unlocked the door, he opened it just enough to see the top of his bed. He said it was not dark but like "dusk" and the curtains were open. He did not turn the cell night light on. The fourth PCO said that by the way the quilt on the bed was creased and "lumped", he believed the man was in bed. Having unlocked all the cells, the fourth PCO returned to the office.
69. The fourth PCO confirmed to the investigator that the light fitting in the man's cell was in the centre of the ceiling. He did not look through the door observation panel or open the door wide enough to see the centre of the room and so it is likely that he would not be able to see the light fitting.
70. The fellow prisoner told the investigator that he was good at remembering faces. As the prisoners arrived to collect their breakfast, he realised that the man was not amongst them. Although the prisoners could choose not to have breakfast, he knew that he was still new to the prison, and collected a carton of milk to take to him.
71. When the fellow prisoner arrived at the man's cell, he saw that the door was "ajar" and the cell was "in complete darkness". He walked in and put the milk on a side table. As he turned to speak to him, who he believed was on the bed, he realised that he was hanging in front of him suspended from the light fitting. The fellow prisoner immediately ran to the unit office.

72. The fellow prisoner was distressed as he ran into the wing office and told the fourth PCO that the man had hung himself. The fourth PCO immediately followed him back to the cell. The fellow prisoner grabbed hold of the man, lifting him up to take the weight off his neck. A chair was beneath him with one of his feet on it and a letter with his partner's name on it. The fourth PCO said the ligature looked as if it was a bed sheet. His lips were blue, his tongue was swollen and his mouth open. The fellow prisoner told the fourth PCO to cut the ligature which held the man to the light fitting.
73. The fourth PCO immediately used his radio to contact the Control Room (recorded at 8.22am on the Control Room log). He asked the Oscar 1 (officer in charge of the prison) the Residential Manager and healthcare staff to attend. The fourth PCO used his ligature knife to cut the man down. There were two beds in the cell and the fellow prisoner laid the man on the bed on the left hand side. He noticed that the bed appeared as if it had been slept in and that he was no longer wearing his yellow shirt. Having been in the army where he had first aid experience, he checked the man for any signs of life, but could find none.
74. Another PCO told the investigator that she was the duty Control Room operator that morning. She received a call from the fourth PCO at 8.22am requesting Oscar 1 and healthcare to come to the Induction Unit straightaway. The control room PCO said that his voice sounded as if he was in shock. She immediately alerted Oscar 1 and healthcare to go to the unit. Although the fourth PCO had not requested a first response team (the PCO staff responsible for responding first to incidents), the control room PCO believed that something was seriously wrong by the tone of his voice. She therefore contacted a PCO, who was in the sports centre, to go to the Induction Wing to assist if necessary. Some seconds after, the control room PCO said that the fourth PCO requested Oscar 1 and healthcare again. She told him that they were on their way and he should not panic.
75. The Registered General Nurse (RGN) told the investigator that she received a call over her radio to attend the Induction Unit immediately. No code was used to indicate the seriousness of the incident. The Healthcare Unit is situated underneath from the Induction Unit and she quickly ran upstairs.
76. A nurse told the investigator that it was approximately 8.16am that the call to attend the Induction Wing came through on a second nurses' healthcare radio. The message was "first response could you please attend Induction Unit as soon as possible". The nurse went to the pharmacy to collect the triage emergency bag, which is the normal medical bag taken to any first response call by healthcare staff. It took her around a minute and 30 seconds to do so and return to the Induction Unit to join the second nurse.
77. When the second nurse arrived on the Induction Unit, the fourth PCO was standing on the landing pointing into the man's cell. She went inside the cell and saw the man lying face down on the left hand bed with what appeared to

be a ligature still around his neck. The fellow prisoner told the RGN that he found the man hanging.

78. The RGN immediately asked the fourth PCO to help turn the man on to his back so she could assess him and start cardio pulmonary resuscitation (CPR) if necessary. She asked him for his ligature knife to remove the ligature from around the man's neck. As she attempted to cut it, the ligature came away in her hand.
79. The man was not breathing and the RGN could not find a pulse. She began CPR, as the nurse arrived with the triage emergency bag. The RGN immediately told the nurse that the man had been found hanging. All the medical equipment (including the oxygen, defibrillator machine, bag and mask) was needed. The nurse went on to the wing landing and shouted downstairs to her nursing colleague (who was waiting to see if further assistance was required) to collect the rest of the medical equipment, which was only located in the healthcare unit. The RGN told the investigator that, had the emergency code come through as a Code 1, the emergency equipment would have already been taken.
80. The RGN continued trying to resuscitate the man. The nurse returned, accompanied by her colleague. The prison doctor who had arrived early for his clinic, accompanied the two nurses to the cell. The RGN updated the doctor about the man's condition and all three used the medical equipment to try and resuscitate him.
81. The PCO who was in the sports centre told the investigator that he received a telephone call from the Control Room. He was told to go to the Induction Unit immediately but was given no more details. He said that although the prison has a code system, and in particular a code 1 which indicates a suicide attempt, it was rarely used. He arrived approximately a minute after he was notified and saw healthcare staff attending to the man. The fourth PCO was standing on the landing and seemed to be flustered, so the PCO from the sports centre swapped his keys (the fourth PCO's cell keys were specifically for the Induction Unit) and began to return the other prisoners to their cells. The fellow prisoner was clearly upset and the PCO from the sports centre informed the Oscar 1, who had just arrived on the unit, that a Listener would be required for him.
82. At interview with the investigator, Oscar 1 said he responded to a radio call to attend Induction immediately. He was given no details as to what type of incident he would be faced with. He said that emergency Codes 1, 2 and 3 are specific to healthcare. Other emergency codes (first response or general alarm codes) are used when officers' assistance was required.
83. When Oscar 1 arrived at the man's cell, he observed CPR being carried out by healthcare staff including the prison doctor. He was met by the fourth PCO who was distressed and explained what had happened. The PCO from the sports centre also gave him an update of the situation. The control room PCO confirmed that Oscar 1 contacted the Control Room to update her on the

situation and an ambulance (recorded on Control Room log as 8.26am) was called. Oscar 1 removed the fourth PCO and the fellow prisoner from the landing to offer support and to await healthcare's assessment of the man.

84. At interview, the prison doctor said that he quickly assessed the man and found that he was not responding to commands, was cold, with a blue coloration of the skin and a deep indentation and bruising around the neck just above his larynx. The man's lips were swollen and his mouth and both arms were stiff. Throughout the prison doctor's examination the nurses continued CPR. The prison doctor could find no signs of life and he pronounced the man's death at 8.30am. The paramedics arrived at this point.

After the man's death

85. Oscar 1 instigated the death in custody contingency plans and ensured that the relevant agencies were informed of the man's death. He ensured the cell was sealed to await the arrival of the police and the duty director. The outgoing post was checked and a letter was found to the man's partner. The Director confirmed that the letter contained no reference to the man taking his life.
86. The police recovered a note which was still attached to an A4 pad in the man's cell. The note asked the prison to telephone his partner and to tell her that he could not live without her. He referred to another man he believed she was seeing and ended by writing "Tell her ill always love her and her child that's why I carnt live no more! Sorry [partner],Love you, ask her to inform my sister for me".
87. A hot de-brief meeting (held immediately after a serious incident) was conducted by the Duty Director. Staff were given the opportunity to discuss the events of the morning and further support was given. The Duty Director said that it was rare at Wolds for the staff to have to deal with an incident such as a hanging. The care team attended the prison and went about providing support to staff. Support was also offered to the fellow prisoner and other prisoners.

Next of Kin

88. The man's next of kin was listed as his father. Around 2.00pm, the Director and the prison chaplain arrived at his father's home and broke the news to him and other members of the family. The man's partner was also visited that afternoon. The man's family were given information and contact numbers for the prison and coroner as well as being offered financial assistance with the funeral. A memorial service was later held in the prison chapel and attended by a number of prisoners who knew him.

Post mortem

89. The post mortem report confirmed that the cause of the man's death was "hanging". No alcohol or drugs were found to be present in his blood.

ISSUES

Clinical care

90. The clinical review makes six recommendations. I refer here to those most pertinent to my investigation. The clinical review will also be shared with the PCT.

The man's reception health screen

91. When the man arrived at Wolds, the initial medical admission assessment was undertaken by a prison healthcare assistant. The clinical reviewer notes that there was very little detail in the initial assessment and the information recorded was in tick box form. However, no concern was raised in respect of depression, self harm or drug use and he was assessed as fit for work.
92. Healthcare assistants are not professionally qualified and the clinical reviewer questions the effectiveness of a screening undertaken by someone at this grade. In particular, the clinical reviewer refers to questions answered by the man regarding his mental health. No mental health risk factors were identified by the healthcare assistant. The clinical reviewer does recognise that, even if this assessment had been undertaken by a registered nurse, there is no evidence that it would have prevented the man's death.

The clinical reviewer makes the following recommendation:

The Head of Healthcare should review the appropriateness of unqualified staff undertaking reception health assessments.

The man's contact with Induction Unit staff

93. The man only spent one full day on the Induction Unit. He raised one concern, which was that he did not have enough telephone credit to contact his partner. This was quickly dealt with by the PCO colleague who later facilitated a telephone call. The PCO colleague was the only officer to have much contact with the man at Wolds and he was shocked that he had taken his life.

Roll check

94. The purpose of the roll check is to physically count the number of prisoners on each wing within a prison and to ensure the well being of each prisoner. Two issues arose in respect of the roll check carried out by the PCO on the morning of 8 May.
95. The PCO said that, when conducting roll checks, he would check that the right number of people were in the cell. He would not always check for signs of life, even when this was not obvious, for example if a prisoner appeared to be asleep. Although not a factor in this particular case, the practice contravenes

the local roll check instructions which require a check of the well being of prisoners.

96. Secondly, the PCO was interrupted by a cell bell alarm whilst carrying out the roll check on the morning of 8 May. Having dealt with this, he believed he returned to the Induction Unit and finished checking the last three cells to complete his roll check. In hindsight at interview, the PCO was not certain if he actually carried them out.
97. Given this, there is a possibility that the man's cell was not checked and I cannot say whether he was already hanging from the light fitting when the roll check took place. If he was and the procedures had been carried out correctly, it is possible that he would have been found earlier and an attempt at resuscitation made sooner with a better prospect of success.
98. Although in interview staff confirmed their awareness of their responsibilities for roll checks, there were problems on this occasion. I do not criticise the officer for attending to the cell bell alarm. However staff should be aware that they can be interrupted but should ensure that they complete the check on their return. Roll checks are of the utmost importance and should be completed as per local protocol to uphold the security and health and safety responsibilities of the prison.

The Director should urgently review the roll check procedures and remind staff of their responsibility to follow the local instructions.

Unlock procedures

99. The fourth PCO confirmed that he unlocked the man's cell but did not look through the cell observation panel first. He said that he only opened the cell door a few inches and could see lumps in the bed, which he believed was the man sleeping underneath the sheets. He did not communicate with him or confirm that he was alive.
100. The man was then discovered by a prisoner about ten minutes after the cell has been unlocked. He was hanging from the light fitting in the middle of the cell. He was hanging when the cell was unlocked and it is likely that he could have been seen had the officer looked through the observation panel. Indeed, if the door had been opened wider, it is also possible that his body would have been seen. The investigator viewed the cell when he visited Wolds, and believed it would have been difficult for the fourth PCO to judge whether the man was alive in bed given how he opened the door.
101. In accordance with Wolds' roll check procedures, staff must satisfy themselves that an offender is actually present and if they are sleeping, counting a lump in the bed should be avoided. Similarly, at lock up and unlock, staff must satisfy themselves of the offender's well being, by making a physical check of the offender and, where possible, speaking to the offender.

102. The staff who responded to the man said that his mouth and arms were stiff. This suggests that he had been hanging for longer than the ten minute period between the cell being unlocked and the fellow prisoner discovery.
103. The fourth PCO did not follow the roll check procedures. If he had done so, the man might have been discovered at unlock. Staff should be reminded about the importance of carrying out roll checks and unlocking responsibilities properly. It would also be good practice for staff to ensure that all prisoners who do not collect their breakfast (which they are not required to attend) are checked for their well being.

The Director should remind staff of their responsibilities and the procedures for the unlocking of prisoners.

Response when the man was discovered

104. The fourth PCO raised the alarm by requesting Oscar 1 and healthcare. The clinical reviewer noted that healthcare staff responded quickly following the alarm, partly because they were situated directly below the Induction Unit. The fellow prisoner appeared to play a key part by holding the man's body weight to alleviate the pressure around his neck, so that that the ligature could be cut.
105. However, the standard emergency Code 1, which would have alerted healthcare staff to a life threatening situation, was not used. Nor was an initial description of the incident given. Staff were therefore unaware of the nature of the emergency until they arrived at the cell and so did not take all the appropriate emergency equipment.
106. When nursing staff arrived, CPR was instigated immediately and other medical equipment including the defibrillator and oxygen was brought to the cell. The prison doctor was also available to assist and I believe that every effort was made to resuscitate the man.
107. Staff should be reminded of the importance of using the correct code system as it alerts all the staff who are required to attend and provides information that could assist them deal with the incident. Staff told the investigator that the Code 1 alarm was not used very often. Indeed this is the first self-inflicted death to have occurred at Wolds since April 2004. Nonetheless, it is imperative that relevant codes are used as they ensure that all necessary action and equipment is immediately taken to deal with a life threatening situation.

The Director should remind staff of the importance of using the correct emergency code system when requesting staff and healthcare assistance.

108. The investigator also noted that medical equipment was only located in healthcare unit and there were no other designated points around the prison for equipment to be stored. Although this had no bearing on this particular

case, it was apparent that had an emergency arisen on a wing further from the healthcare unit, staff might not have been able to respond as promptly as they did. Carrying all the emergency equipment, which is heavy, would no doubt contribute to delays.

109. In the Ombudsman's previous investigation at Wolds, it was recommended that consideration be given to having sufficient defibrillation machines available within the prison, and that sufficient staff be trained in their use. At the time of writing this report, the office was still awaiting the Prison Service response to this recommendation. I therefore repeat the recommendation here. (Following the issue of this draft report, I have been informed that the Prison Service has accepted the recommendation made in the previous investigation.)

The Director and Head of Healthcare should review the viability of having medical equipment located in specified locations throughout the prison.

First aid training

110. The fourth PCO was the first officer to respond to the emergency. His first aid certificate had expired. The Ombudsman has previously recommended in other investigations that first aid training is provided for all staff in contact with prisoners. I suggest that basic life support or first aid training should be reviewed for frontline staff to ensure that their knowledge of resuscitation procedures is up to date. However I acknowledge that it is doubtful that it would have made a difference in this case, as healthcare staff arrived promptly.

The Director should review the need for first aid or basic life support training for staff on frontline duties.

Ligature points in cells

111. When the investigator interviewed a prisoner on the Induction Unit, he said that as a Listener, he had previously raised concerns at a safer custody meeting about the light fitting being used as a ligature point. This had been recorded in a letter to the prison dated 10 February 2009. I am pleased to report that since the man's death, the Duty Director has confirmed that action has already been taken to rectify all such light fittings.

The use of the term "e-mail me"

112. When speaking to his partner, the man had on more than one occasion used the expression "e-mail me". Security reports from his previous periods in custody confirmed that he could receive e-mail messages via illegal mobile telephones, which he was found with on many occasions. No security intelligence information was provided to the investigator to suggest he was in possession of a mobile phone in Wolds around the time of his death. It is

therefore not clear what the man was referring to when he asked his partner to e-mail him on the days before he took his life.

CONCLUSION

113. The man spent periods in custody in Leeds and Lindholme before transferring to Wolds. There were no concerns that he would harm himself at either of these prisons. When he arrived at Wolds, no concerns were highlighted in respect of his well being. He reported no issues with drugs, alcohol or having had mental health problems. He quickly settled on the Induction Unit and no one identified any signs that he might harm himself.
114. Reviewing the phone calls that the man made to his partner, it is clear that he missed her. Whether being in prison made him feel insecure about their relationship is not clear. He made no reference to wanting to harm himself in any of their conversations, although he did say in the note he left that he could not live without his partner.
115. I mention in my report that the man uses the term “e-mail”, but there is no evidence to suggest that he was in contact with his partner after he was locked in his cell the evening before he was discovered. We can only speculate that at sometime during the night his frustrations got the better of him and resulted in feelings of hopelessness which ultimately led to him taking his life.

RECOMMENDATIONS

1. The Head of Healthcare should review the appropriateness of unqualified staff undertaking reception health assessments.
2. The Director should urgently review the roll check procedures and remind staff of their responsibility to follow the local instructions.
3. The Director should remind staff of their responsibilities and the procedures for the unlocking of prisoners.
4. The Director should remind staff of the importance of using the correct emergency code system when requesting staff and healthcare assistance.
5. The Director and Head of Healthcare should the review the viability of having medical equipment located in specified locations throughout the prison.
6. The Director should review the need for first aid or basic life support training for staff on frontline duties.

The prison Service have accepted all the recommendations.